

AMERICAN SOCIAL INSURANCE

R E V I S E D E D I T I O N

by

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To the Memory
of
HARRY ALVIN MILLIS

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INTRODUCTION

SOCIAL insurance is newer and less fully developed in the United States than in most other civilized countries. Workmen's compensation, the oldest form of social insurance in this country, dates from 1911. The first state unemployment insurance law was passed in 1932 and became effective in 1934. Impetus to the enactment of unemployment insurance laws in all other states was afforded by the Social Security Act of 1935. Another part of that Act established the national old-age and survivors' insurance system. A few public employees' retirement systems date from the early years of the present century; the largest of these systems, the United States Civil Service Employees' Retirement System, came into being in 1920. The present railroad retirement system was established in 1937. The railroad unemployment insurance law dates from 1938 and in 1946 was extended to include cash sickness benefits. The first state cash sickness (disability) insurance law was enacted in 1942, but most states still do not have such laws. Nowhere in the United States is there compulsory health insurance, which in other lands is the oldest and most comprehensive form of social insurance.

Thus, while recent and incomplete, social insurance has attained great importance in the United States. The national old-age and survivors' insurance system is the world's largest insurance institution. Eighty million living Americans have credits in this system, and, under existing legislation, somewhat more than half that number can look forward to retirement benefits on attainment of age 65. More than 2,000,000 people are now on the benefit rolls and this number is rapidly increasing. Covered by state unemployment insurance laws are over 35,000,000 workers, constituting more than three-fourths of all industrial employees of the country. More than 4,000,000 workers drew some unemployment insurance in 1948, the peak year for civilian employment in the nation's history. The coverage of the workmen's compensation acts is

somewhat less inclusive, but these laws afford medical aid and partial compensation for wage loss to the great majority of the victims and their dependents of the more than 2,000,000 industrial accidents which annually occur in this country. Nearly all of the railroad and air line employees are covered by old-age, unemployment insurance, and disability compensation laws. Substantially all employees of the national government and more than half of the state and municipal employees are included in special retirement insurance systems, and many also enjoy survivors' insurance protection.

Social insurance as it now exists in the United States is far from adequate. The largest existing program, old-age and survivors' insurance, excludes from coverage one-third of the nation's working force, and a large percentage of those covered will never be able to qualify for benefits under existing eligibility rules. The benefits, while extremely liberal in relation to the contributions of the beneficiaries, are far from adequate for support, averaging only \$25 per month. Unemployment insurance, while providing benefits which are three times as liberal on the average, is limited in duration and restricted by many qualifying conditions. Workmen's compensation still does not exist for large groups of workers and its benefits are sadly out of line with prevailing price levels. Despite great advances in voluntary forms of health insurance and the recent development of cash sickness compensation as the latest type of social insurance, the great majority of Americans today have no insurance against wage losses resulting from illness and the greater costs of medical care.

Improvement of our social security programs is overdue. Comprehensive proposals for changes in these programs are now under consideration in Congress. Changes in state legislation occur in nearly all states in every legislative session. Social insurance is a developing and changing group of institutions whose importance seems destined to greatly increase in the years immediately ahead.

Naturally, there are differences of opinion as to the soundness of this trend. There are many who are concerned about the growing costs and fearful lest social security impair self-reliance and habits of thrift and industry. They see in this entire development a great threat to our economy of free enterprise and the danger of a police state.

Those who believe in social insurance, as I do, see in it a bulwark

for a free economy and a democratic government. They regard the increasing attention given social security the world over as a necessary, perhaps an inevitable, consequence of an aging population, of industrialization and urbanization, of technological progress and the advances of science and medicine, of rising standards of living and a growing concern for the unfortunate and underprivileged. To them, social security means not a feather bed provided at public expense, but a net to catch those who fall, or rather, a floor which will assure all Americans in all contingencies of life a minimum income sufficient for an existence in accordance with prevailing concepts of decency. Anything above such a minimum, the citizens individually must still provide for themselves, through private insurance and other savings.

A civilized people cannot exterminate its aged members in gas chambers or consign its poor to starvation or its sick to neglect. From the earliest days of settlement in this country, it has been a legal obligation of the government to provide for the care and support of all who have no other adequate means of support. The problem confronting the United States today is, not whether public provision shall be made for the growing number of dependents, but whether this shall be done exclusively through public assistance or universal pensions provided on a noncontributory basis from general taxes or, mainly, by reliance upon contributory social insurance. In establishing social insurance institutions for coping with the economic consequences of some of the major risks which lead to poverty and dependency, the American people have indicated their preference for contributory insurance. But the basic issue presented has by no means been settled.

What methods the United States should adopt for dealing with the increasing numbers of the aged and other dependents in its population is one of the most pressing of current domestic problems. Our great difficulty lies in the complexity of the problem and the piecemeal and differing structure and functioning of the existing social security institutions. For college classes, this difficulty has been augmented by the lack of an up-to-date, comprehensive textbook. But few books have been written in this country dealing with social insurance. Most of them are old and nearly all the others deal only with very limited aspects of social security as it has developed in this country. An intelligent, comprehensive book is badly needed, both for college teaching and as a convenient

source for accurate and current information on all aspects of this subject.

Professor Gagliardo's *American Social Insurance* fills this need. The author deals with all of the several social security institutions in the United States, including the generally neglected but not unimportant public employees' retirement funds and the railroad retirement and unemployment insurance systems. He also devotes a good deal of attention to social security institutions which are social assistance rather than social insurance programs in the technical usage of these terms. In addition, he discusses in detail the many voluntary, private types of insurance against wage loss resulting from illness and the costs of medical care. Such a comprehensive treatment of "social insurance" is one of the strong points of this book, because social insurance (technically defined) is but one method of dealing with the basic problem of providing the vitally necessary minimum income to all Americans in all contingencies of life.

Outstanding in Professor Gagliardo's treatment of the subject is his impartiality. He presents facts and states positions, but he does not propagandize or speak with Olympic finality. His facts are accurate and as up-to-date as is possible in any such comprehensive treatise.

This is a much needed and timely book in a field of great present significance and almost certain greater future importance to the United States and all elements in its population. Its publication will make it easier for all students to gain a knowledge of the facts which are essential for the development of sound public policies.

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PREFACE TO THE REVISED EDITION

THE PROGRESS made in American social insurance during the past 20 years has been truly phenomenal. In stature and proportions, social insurance is now unquestionably one of our major social and economic institutions. The object of this book is to present a reasonably full-length picture of that institution. This is not easy to do, for some of the parts have become exceedingly complex and changes, many of major proportions, are constantly being made. Yet the general framework presented here is likely to remain essentially valid, at least for some time. Major additions to the structure will no doubt be made, especially in the fields of health insurance and disability annuities. But at the moment it does not appear likely that these changes will come in the near future.

Some material is included in the text that, strictly speaking, is not social insurance. The movement for old-age pensions was one of the forces leading to our present retirement system, and some retired insurance beneficiaries receive supplementary old-age assistance grants. The common law applicable to occupational injuries, together with legislative and judicial modifications of it, is introduced as background to workmen's compensation. That body of law is still applicable to many occupational injuries. In the field of health we do not have anything in the way of social insurance beyond a few cash disability benefit laws. But we do have voluntary nonprofit prepaid hospital and medical care programs. These voluntary plans go some distance in filling the social insurance gap, and are likely to go even further. They may very well be laying down the foundation upon which a compulsory national system will be established.

Foreign social insurance systems are not treated in this text. For better or for worse, it is with and within our own programs that nearly all of us will live and work. Not a day goes by that we are

not in some way affected by one or more of the programs. They have become so significant that they will play an increasingly important role in our deliberations on social policy—private as well as governmental. Modifications will continue to be made, but they will be made in the light of American ideals, institutions, conditions, and experience.

I have not been concerned in this book with the operating problems encountered in the administration of our social insurance programs. Nor have I been much interested in stressing the many weaknesses and defects of specific programs or plans. It is not that operating problems and structural defects are unimportant. As our system becomes more complex, operating problems tend to become increasingly delicate, and structural defects or weaknesses will be matters of concern until our accomplishments and goals more nearly coincide than they now do. I have for the most part been concerned with a description—in simple terms and to a limited extent—with what we have, how we got it, and what some of the principal results have been. Those who have this factual background should be better able than they otherwise would have been to make the reasonable interpretations and evaluations so important to the determination of public policy in a democracy.

The general plan followed in the presentation is simple. The area of social insurance is divided into four major fields: old age, unemployment, occupational disability, and the broad category of health. For each of these major divisions there is first a chapter which presents the nature and extent of the problem or problems involved. Next there is a brief statement of the historical background of the social insurance movement in that field. Then comes an exposition of existing programs established in that field. Although some references are made to major changes that have taken place in specific programs, emphasis is laid on the structures as they now exist. Finally there is a summary review of results, with special reference to taxes, benefits, and beneficiaries. In the concluding chapter, attention is devoted to the major factors involved in the development of social insurance, and some attention is devoted also to deficiencies and to proposed courses of future action.

The principal changes made in our social insurance programs since 1949, including those made in 1954, are incorporated in this edition. This has meant intensive revision of certain parts of the text, especially those treating the Federal Old-Age and Survivors In-

surance system. Operational data have been made current in so far as that has been practical. However, the basic pattern of the original edition has not been changed.

I am deeply indebted to many people for the assistance they have given in the preparation of this text. I am one of the many who were inspired by the late Professor Harry Alvin Millis, and my special indebtedness to him is more appropriately expressed elsewhere. Professor Edwin E. Witte read the entire original manuscript and his counsel has left an indelible imprint on the entire text. I am grateful to all the others, not named here, who helped in so many different ways. The responsibility for all errors and shortcomings that remain is mine.

DOMENICO GAGLIARDO

University of Kansas
February, 1955

PART ONE

INTRODUCTION

CHAPTER ONE

INSECURITY AND INSURANCE

TO SAY that we live in an insecure environment is to speak a truism, although it is an important one. Wars, plagues, "acts of God" such as floods, fires, and earthquakes, to mention but a few of them, are almost unalloyed evils that play havoc with our security. Yet it is a strange and even ironic fact that many of the forces and events making for a rich and full life should also make for insecurity. Atomic energy, when harnessed to our productive organization, will result in a richer and fuller life, but its potentiality as a destructive force is disquieting, even appalling. Bacteriology has done much to improve health, but the specter of bacteriological warfare plagues mankind. Private enterprise has built an effective but sensitive productive organization that booms and busts, doing both good and evil.

INSECURITY

The growth and decay of civilizations, the rise and fall of empires and peoples, changes in the methods, processes, materials, and organization of production—these constitute major elements in the ebb and flow of life. In a dynamic civilization or society, risk, which is the chance of loss, dogs every step we take, and many come upon evil days. We go our way knowing that an unkind fate will choose one of us for its next victim, but not knowing who will be chosen, when the blow will fall, what weapon will be used, or how much damage will result.

Our Concern with Insecurity. For many good reasons, the problem of insecurity has been very much in the forefront of public concern in recent years. The great business depression which began late in 1929 seriously disrupted American social, political, and economic life, and introduced many to an insecurity they had smugly or blindly supposed would never be their lot. It brought ruin and mis-

ery and suffering to millions, and led to the adoption of drastic experiments in relief and recovery, some sound, some fantastic, all costly.

The growth of a form of despotism, known in Italy as Fascism and in Germany as Nazism, thoroughly disrupted social, political, and economic stability in Europe and brought insecurity, unrest, and disorder to most of the rest of the civilized world, including the United States, where the two despots—Hitler and Mussolini—had a surprisingly large number of admirers and not a few collaborators. Vicious and barbaric persecutions of political, racial, and religious minorities, more horrible perhaps than those of the Middle Ages and early modern times at their worst, were practiced by Hitler and his gangsters. The Japanese, allied with Germany and Italy, were out to dominate Asia, and they had even wilder aims, including the conquest of the United States.

The second World War, which resulted from the aggressiveness of Fascism, together with the Sino-Japanese war already in progress, almost completed the disruption of European and Asiatic life, and it drastically altered our own, even before this country became one of the belligerents. In Europe and Asia, famine, destitution, malnutrition, pestilence, destruction, civil war, and lawlessness again cursed people most of whom had for centuries known a somewhat better life.

When it became clear that we would have to fight, and particularly after we were attacked, the major elements of our industry were converted from peacetime to wartime production with amazing thoroughness and rapidity. The threat to our security, to our independence, welded us into a unified and purposeful nation. More than ten million men and women were mustered into our armed forces. Yet even more, mostly women, were added to the army of wage earners employed in the production of equipment, munitions, and supplies.

Despite the fact that a tremendous amount of our effort was devoted to production for war, the standard of living of our workers did not materially decline, thanks to the increased productivity of our system and, unfortunately, to our consumption of some capital and inventories. We had butter and guns. The war cost us heavily in terms of battle and industrial casualties and in human sorrow, but not so heavily in terms of material goods.

After the war was won, the problem of reconversion to a peace-

time economy became of prime and pressing importance. Significant changes had taken place in the growth of our labor force, in technology, concentration of population, and location of industry. Elaborate governmental controls had been established to guard against inflation, to allocate labor and resources, and to ration scarce commodities. A slump in business activity with resultant unemployment was expected by many to follow the cancellation of huge war contracts and demobilization of the armed forces. How to give private enterprise sufficient rein to enable it to take over, continue and even increase economic production without having inflation and its disruptive consequences, was only one of the major problems confronting the American people. Considerable economic confusion was expected and some of it did in fact materialize, but surprisingly little.

The bonds that held the allies together in their common struggle against totalitarianism gave way with the ending of hostilities. A new despotism, masquerading in the guise of democracy, again divided the world into two opposed camps. The spread of Communism revived fears which were allayed with the defeat of the Fascists. The task of stemming the tide of Communism fell mainly to the United States, the most powerful and wealthy of the democratic nations. Emergency relief to other democratic peoples put something of a strain on our own economy, but more on our unity, and contributed somewhat to our postwar inflation. That inflation reached proportions that revived the fear of another colossal depression, and with it of Communism.

These are some of the major factors that account for our recent concern with security, that account for our strong propensity to stress the importance of security rather than the opportunities that go along with risks and insecurity. Some progress is being made in the solution of the general problem. But it would be foolish to suppose that stability will be achieved or even approached in the near future. The specter of insecurity will certainly haunt mankind for many years to come, probably for generations, possibly forever.

The Trend of Insecurity. We have, then, become exceedingly conscious of insecurity because we have been living with so much of it in recent years. And we are striving with vigor and determination to solve the problems which that insecurity poses. Yet it would be a mistake to suppose that insecurity is a peculiarly modern phenomenon, or that modern man is afflicted with more of it than were

his ancestors. For insecurity has been characteristic of all times, all countries, and nearly all aspects of life.

Prehistoric men battled the elements, diseases, wild animals, and other men, and they struggled to wrest food, clothing, and shelter from an environment that was sometimes generous, but was more frequently niggardly. They lived rugged, ragged, uncertain, and short lives, existing on what they could find in their immediate environment and migrating elsewhere when necessary and possible in search of the barest essentials. "Like the lower animals, whom they resembled, the earliest men hunted, fished, gathered berries, moss, lichens, seized such small animals as snakes and lizards, ate the insects that crawled beneath their feet or that swarmed on their own persons, and grubbed in the ground for wild bulbs and roots."¹ Hunger, sickness, injury, and death from fire, flood, pestilence, and pillage unrelentingly stalked them and their families night and day. Death, suffering, and danger are hard to bear, even when their causes are fairly well understood. They must have been doubly so for men who did not understand and who saw them as the doings of evil spirits. It is difficult to imagine them in security of any kind for more than brief periods of time at best.

As primitive peoples found good land, acquired some of the arts of agriculture, settled down into communities and later developed handicrafts and engaged in commerce, life for them became easier; or perhaps it would be better to say that life became less harsh and cruel. All of the old causes of insecurity still existed, but they did not all bear down so heavily or so persistently. Food was more abundant, although famine and hunger were not infrequent. Sickness probably was less severe, although pestilences, such as typhus, pneumonia, and smallpox killed more people, because there were more of them to kill and because they lived closer together. Organized war took its toll, and sudden violent death from marauders constantly stalked the traveler, and not infrequently the settler as well.

Economically, villages and towns were markedly successful as instruments for reducing the evils of the old insecurities. Food, clothing, and shelter became more abundant and varied, and some small advances were made in sanitation and cleanliness. The growth of population is ample evidence that living conditions were improving, and the development of the arts proves that there was wealth to

¹ N. S. B. Gras, *An Introduction to Economic History*, Harper & Brothers, 1922, p. 4.

spare for capital equipment and for the finer things of life; wealth to spare at least over and above what to us appears to have been for most people a very meager existence. The roots of modern individualism, also a flower of abundance, began to take hold.

Specialization of labor, itself possible only after people have more than the barest necessities, proceeded apace and further increased productivity and well-being. But specialization, particularly where it was highly developed and widely applied, also brought a new kind of insecurity, i.e., that resulting from disequilibrium in the economic system. A wage-earning class developed and unemployment became common. Inability to work in old age acquired a new meaning, namely dependency upon charity in the form of money rather than as a share in the common stock.

Modern industrialization has made possible productivity beyond the wildest dreams of ancient and medieval man. Great concentrations of capital, wealth, and people are commonplace in the western world. And throughout the hinterland, people and wealth are more abundant than ever before. Great strides have been made in science, technology, organization, medicine, the arts, education, religion, and government. Specialization has become so intensive that self-sufficiency is almost nonexistent. Nearly every person employed is engaged in producing items for sale to others, and most workers perform only a part, and usually a small part, of the process of producing a completed item. There thus exists an extraordinarily high degree of interdependency among employed persons, an interdependency which extends to an appreciable extent even beyond the boundaries of our country. For normally a small, but vital, part of our production is for foreign markets, and foreign commodities in substantial quantities are consumed in this country.

The gigantic and extremely complex economy that yields fabulous quantities and incredible varieties of goods and services is, however, made amazingly sensitive by the very specialization which makes it possible. The pricing mechanism operated by private individuals and groups motivated by a desire for gain which regulates the system never works perfectly and frequently breaks down badly. New industries are born, some old ones stagnate and others shift their location. Operations take on higher speeds and new materials and processes replace old ones. Changes come rapidly.

Thus we have some unemployment always and mass unemployment in depressions. Job insecurity seems greater than it has ever

been. Industrial accidents and occupational diseases persist and some types increase. For one reason or another, many reach old age without any means at all or with not enough to support them for their remaining days.

Measures of Insecurity. It is a moot question whether economic insecurity is now greater or less than it was in past times. The real income, meaning the quantity, quality, and variety of goods and services consumed, of the mass of people in this country today is unquestionably higher than it was in the early days of our history, higher in fact than it has ever been before. The average length of life has increased materially, indicating a considerable degree of control over our environment. Indeed, it is fair to say that the mass of our people today are scarcely likely, except on very rare occasions and for short periods of time, to suffer loss of real income great enough to reduce them to the standards of living which their forefathers had considerable trouble maintaining. Today even the poorest are better off than formerly, for charity is more abundant, its distribution well organized, and its acceptance less stigmatized socially.

Yet insecurity is not really to be measured by the total amount of income a people enjoys, nor even by its irregularity. It is rather to be measured by the degree of uncertainty which exists of actually realizing that income. Not how little or how much or how irregular, but how uncertain. Thus it may be said that a people having a very low standard of living and who are actually certain of realizing that standard enjoy more economic security than does a people with a high standard who are highly uncertain as to whether they will actually be able to maintain that standard.

Measured by this test, i.e., the relative certainty of actually receiving an accustomed standard of income, it is not easy to determine whether insecurity has generally increased or decreased in the United States. President Roosevelt in his initial Message to the Congress on social security said that his proposed legislation was an attempt to "return to values lost in the course of our economic development and expansion." Because it is so highly specialized and varied, because it is based on unstable money as a medium of exchange, and because private enterprise is the mainspring which makes it operate, the modern economy is much more delicate and sensitive and can be thrown into disequilibrium more easily and more frequently than could the older economy. Thus to many it seems reasonable to suppose that insecurity has increased over the

years, that security is one of the "values lost in the course of our development and expansion."

The evidence that would be needed to give a conclusive answer to this question is not available. It is of course true that the Great Depression of 1929 dwarfed all previous ones by comparison. But such information as is available on previous business depressions does not indicate any tendency for them to increase in either frequency or amplitude. Information on rates of unemployment, which is sketchy for early times and not too good for the past fifty years, does not support the view that stability of employment is declining. The rate of sickness is not increasing, but is actually decreasing. There is some reason to believe that industrial accident rates are higher in a mechanized than in a handicraft economy, but there is also evidence that for many years now both frequency and severity rates have been generally declining.

The total numbers of persons affected by these insecurities have naturally increased with the growth in population and increase in the percentage of the population "gainfully" occupied. It is true also that the rates in the United States are generally appreciably higher than in other industrialized countries. Yet these last two facts do not prove, or indeed even suggest, that insecurity has increased.

The Trend of Insecurity and Social Policy. While it would be worth while to know whether insecurity is increasing or decreasing, that information is not really necessary in order to decide whether social insurance should be adopted or expanded. For assuming even that the extent of insecurity is declining, there might still be enough of it to be considered socially harmful or undesirable. The proportions of time lost through unemployment, industrial injury, or sickness, or the proportion of aged dependent persons to the total might be low. But in a large society, low proportions mean large absolute totals. Furthermore, assuming for the sake of argument that the total amount of insecurity is not generally excessive, yet insecurity might seriously affect certain classes of people, or certain groups within classes, to such an extent that the public would consider it desirable to solve the problem or to reduce its magnitude by the application of insurance methods. Faith in and hope for a better world and not fear of the world as it exists have in truth motivated the movement for social insurance.

The factor then that is decisive in formulating social policy is whether the amount and incidence of insecurity are considered by

the public to justify action. Just how much insecurity is there, what forms does it assume, what groups, or individuals within groups, suffer most from it, what can the country as a whole gain by insuring against it, and finally, can the cost be borne? These are the vital questions the answers to which will indicate whether action is necessary, and if so what kind of action and how much of it should be taken. The questions have been answered, and this country has undertaken comprehensive measures designed to provide protection.

The Meaning of Social Security. Social security in its broadest sense could be conceived to mean a system of guarantees to individuals against loss from major and minor catastrophes arising from social, political, and economic institutions and practices. Modern war and the expropriations that have frequently taken place by the mere threat of war are catastrophes of the first magnitude which arise out of a combination of different institutions and practices. Their effects extend far beyond the areas and peoples directly involved. Any machinery that can be devised to eliminate them or to mitigate their evil consequences is definitely an important element in a comprehensive system of social security, if not indeed the most important single element.

Racial and religious persecutions, arising from the application of certain social and political ideals, are also catastrophes that have in various times and places brought incredible misery to untold numbers. History is replete with examples, and some of those examples are to be found in American history. Guarantees against racial and religious persecutions and discriminations thus also have their place in a broad system of social security. A comprehensive and well rounded education for the masses has been considered by many to offer security against war, persecution and discrimination, and a host of other evils as well. Unfortunately, history, especially recent history, does not lend much support to that view. Education sometimes helps, but it most certainly is not a panacea. And mere literacy can be a source of confusion rather than a cure for it.

Economic Security and Social Insurance. The subject of social security in its broadest sense is far too comprehensive to be discussed authoritatively in one book or by one man. Even economic insecurity, which is but a part, albeit an important part, of social security is too comprehensive. In our economy, for example, the value of money fluctuates and as a result financial losses are suffered by

many. Crop failures and bumper crops likewise seriously affect incomes, especially of farmers and businessmen processing and dealing in farm products. Those phases of economic insecurity are of vital concern to society, but they do not fall within the scope of this study. The same is true of losses suffered as a result of fire, floods, theft, and from a multitude of other hazards that beset us on all sides.

This study will be concerned altogether with a few important hazards confronting workers as wage and salary earners, and with some of the attempts that have been made to provide insurance against those hazards. It will be concerned with insurance against the hazards of old-age dependency, unemployment, industrial injuries, and sickness, although some space will be devoted to payments made to needy persons and to some other allied problems. This has come to be called social insurance.

THE INSURANCE METHOD

Insurance is simply a method of distributing the monetary losses that would otherwise be experienced by some individuals among a large number of individuals through some risk-bearing organization or system. It is a method of ancient origin, so ancient that its beginnings are lost in the obscurity of antiquity. It will be worth while to describe briefly the method of insurance and to indicate the major respects in which social insurance differs from commercial insurance.

The Law of Large Numbers. Nearly every uncertainty that dogs almost every step of man in his many and varied activities presents the possibility, or chance, of financial loss. Many of those uncertainties, such "acts of God" for example as earthquakes, cyclones and tornados, tidal waves, lightning, and floods, are unavoidable. They strike and leave in their wakes death, destruction, suffering, and sorrow. Some uncertainties, such as those involved in the ownership of property or the conduct of a business or profession, are voluntarily assumed as incidental to activities that on balance contribute greatly to the welfare of mankind. The damage resulting from all of these uncertainties can to some extent be reduced by taking proper precautions. But in all of them there is an irreducible minimum of loss, and uncertainty as to who will experience it.

Just where the next blow will fall, then, no one knows. But fortunately it is possible to predict with a reasonable degree of accuracy, for many types of hazards, how many blows will fall and

how much the total loss will be. For it has been found that where large numbers are involved there is considerable regularity in the occurrence of many phenomena. This regularity has been described as the Law of Large Numbers. In more technical language, the actual occurrence of an event and the objective probability that the event will occur approach an equality as the number of exposure units increases.

Thus it is possible to predict with reasonable accuracy how many persons will die in the United States within the next few years and how old those persons will be, or how many buildings will burn and what the total damage will be. But it is not possible to predict who will die or what buildings will burn or how much financial loss any particular individual or individuals will suffer.

The regularity with which blows will fall, the uncertainty as to where the blows will fall, and the amount of loss that will result where large numbers are involved are the bases upon which insurance is built. To be sure, the number of losses involved must be large, and the danger great enough to make the cost of administering insurance small in comparison to the losses. When these conditions exist, then large numbers of people band themselves together, each contributes regularly a small sum of money, and the relatively few unfortunate ones among them who suffer a financial loss are reimbursed from the contributions of the many.

Thus by voluntarily suffering a small and certain loss regularly (premium paid) to a central fund (insurance carrier), each is insured against the possibility of a great and uncertain loss. The security thus purchased is considered to be worth the premium, or price, paid. Organizations, known as insurance carriers, are established to handle the complex details concerned with the enrollment of members, collection of premiums, and the payment of losses. They have increased remarkably in number and variety and strength, especially in the past hundred years, particularly in the United States, and they have cast their beneficent mantle of protection and comfort over the length and breadth of our country and over its people.

The insurance method has been applied to a great many different kinds of risks. It has been applied wherever the total amount of loss can be predicted with a reasonable degree of exactness over a number of years. Truly elaborate systems have been developed, and often policies are "tailor-made" to meet the needs and characteristics

of individuals, firms, or groups. But underlying the maze of peculiarities, which have been introduced partly for competitive reasons, is the simple and fundamental method of distributing among many the losses experienced by a few.

The Benefits Involved. That those upon whom losses would fall in the absence of an insurance system are benefited is quite obvious. Their losses are made up, to the extent that they have insured against them. Many receive in cash benefits much more than they pay as premiums. It is intended that they should.

Yet it is important to understand that those who never suffer a loss and whose small contributions reimburse the stricken ones are also greatly benefited. For although they pay their premiums regularly and receive no cash benefits, they have guarantees against losses that they might otherwise suffer, against the economic burden of uncertainty. They buy a reduction in their burden of uncertainty.

The probability that loss will occur is not affected by the mere existence of insurance, by the distribution among many of the losses suffered by a few. But insurance may lead to a reduction in the probability of loss, and it frequently does. When possible, preventive measures are taken to reduce the number and amount of losses experienced. Protective devices are installed to reduce the loss from such hazards as fire, burglary, and accident. Medical and nursing care may be supplied to reduce the number of deaths at any given age level or to reduce the duration of disability. Premium differentials are usually the reward for the use of such devices and measures. The results are beneficial to the insured persons and to the public as well.

There is, of course, another side to the story, and "from its pages we read a story of cheating, arson, murder, and crime of every imaginable sort. The depths of degradation to which men have stooped to defraud insurance companies is appalling, and little realized by others than those near the business. A complete history of insurance as an institution will be lurid with tales of criminal acts of every sort from petty cheats to crimes so revolting as to throw doubt upon their credibility."² To this indictment should be added the long list of crimes against policy holders committed by insurance company executives and agents who in some instances have "resorted to every

² John Henry Magee, *An Approach to the Study of Moral Hazard*, Insurance Institute of America, 1933, pp. 7-8.

form of trickery and deceit and even forgery and theft in order to escape their honest obligations.”³

SOME DIFFERENCES BETWEEN SOCIAL AND COMMERCIAL INSURANCE

There are many economic hazards to which workers are exposed and for which ordinary commercial insurance has not been provided at all or has been provided only in inadequate volume, primarily because it has not been possible to predict with sufficient accuracy the extent of the losses that are likely to occur. There are other reasons for inadequate coverage. Most people tend to underestimate, or are ignorant of, the extent of danger or uncertainty to which they are exposed, and when they do know they frequently become so accustomed to the danger that they pretty much ignore it. Young people especially have a contempt for danger and a strong faith in their own invulnerability to it. Furthermore, many workers are unwilling or unable to pay insurance premiums, for although the premiums are generally absolutely small they are or appear to be large relative to the workers' incomes. Furthermore, insurance protection is not tangible, like an automobile, a refrigerator, or a radio, but an intangible assurance that for a certain sacrifice a probable loss will be averted. There is also considerable administrative difficulty involved in collecting premiums regularly from persons with small and irregular incomes. Social insurance has been devised to overcome these difficulties.

Social insurance is like all other forms of insurance in that it is based on the same fundamental principle of distributing among many the losses of the few, and doing this through some form of organization or insurance carrier. But there are several characteristics of social insurance which distinguish it from voluntary commercial insurance, as well as from charity, and which give to it what for want of a better term is called a social character. The differences are not always clear-cut, for there are few features in social insurance that have not at some time or other appeared in private commercial insurance. In some instances, the difference may be merely one of emphasis.

³ F. W. Potter, quoted by Albert H. Mowbray, *Insurance*, McGraw-Hill Book Company, Inc., 1930, p. 424.

Minimum Income Provided. One important difference is that social insurance systems are designed to provide incomes that will maintain a minimum standard of living when earnings are interrupted rather than to supplement regular earnings or to make up the entire loss, or nearly the entire loss, suffered. That minimum need not be the same for all recipients, but it may be related to the insured worker's previous productivity or standard of living, and to some extent related to his need.

The ratio of the amount of benefits received by an individual to the actual money loss which he experiences is generally appreciably higher in commercial insurance than it is in social insurance, although even in commercial insurance a part of the risk is usually borne by the insured. In social insurance the minimum is deliberately set at a low figure. It is of course true that a property owner might carry only \$5000 or less insurance on a building costing \$10,000 and that in case of fire he might lose \$5000 or more. But he may carry more if he wishes to do so. That is not usually possible in social insurance systems.

It should be noted that the level at which benefits are set is dictated primarily by social policy and only secondarily by financial considerations in social insurance. The benefits are low, but they are not charity. For the beneficiaries are entitled to them as a matter of right, whether they are needed to maintain a subsistence standard or not. Yet they are generally so low that frequently they must be supplemented from savings, borrowings, or charity.

Premiums Loosely Related to Benefits. A second difference is that in social insurance benefits to individuals are not in proportion to the premiums which beneficiaries pay or which are paid on their behalf. In commercial insurance, a premium of \$5 per month will buy the same amount of protection for every person in the same classification. Thus all property owners who pay a fire insurance premium of say \$5 per month on the same type of structure in the same locality used for similar purposes get the same amount of protection, irrespective of the size and composition of their families or differences in their incomes. It is true that many factors enter into the classification of building types and conditions for insurance purposes, but the complications thus introduced do not violate the cardinal principle that for each dollar paid in premiums the same amount of protection is received. Indeed, the complications repre-

sent attempts to achieve that ideal more exactly. The aim is always to adjust the premium to the risk.

In social insurance, however, that is not the general practice. Benefits are deliberately established to favor those receiving lower incomes or having greater obligations, and individual premiums are related to incomes rather than to benefits. The Federal income-tax law applies progressively higher rates to larger incomes. In social insurance progression is applied inversely to benefits. A good example is the Federal Old-Age and Survivors Insurance system, which requires all workers to pay the same percent premium on income earned in covered employment, up to a maximum of \$4200 per year, but which pays appreciably lower benefits per dollar of premium paid to those receiving high earnings. There are instances where premiums are related roughly to risks, as for example in unemployment compensation where employers with high rates of unemployment generally pay more than those with low rates. But adjusting premiums to risks is not altogether an attempt to relate costs to individual benefits. It is partly an attempt not to interfere with the relative positions of different activities in the economy. Thus social and not financial policy is involved.

Compulsion. A third difference is that social insurance is usually compulsory. The law specifies what industries, employers, employees, and hazards are covered, and what benefits are payable, and individuals covered participate in the system whether or not they approve and whether or not they can buy more and better protection of the same kind at the same or at a lower cost outside of the system.

Legal compulsion, however, is not universal. Some American states, for example, make their workmen's compensation (industrial accident) systems elective. But those employers failing to elect coverage are deprived of certain common-law defenses, and this in effect makes coverage practically mandatory. It is not uncommon for state workmen's compensation laws to authorize employers guaranteeing benefits equal to or higher than those specified by the law to be self-insurers, i.e., to carry their own risks. In some instances, compulsory laws which are not all inclusive in their coverage provide that those not covered may voluntarily elect to come within the provisions of the acts. These, and other, variations are really minor in character and extent and do not invalidate the general statement that social insurance is compulsory in character.

Other types of insurance by contrast are usually voluntary. There is, to be sure, the compelling necessity of protection against the danger of serious loss. But no one is compelled by law to participate. There are some exceptions. Thus insurance against liability for damages resulting from automobile accidents is compulsory for car owners in some states, and the practice is spreading. Furthermore, persons occupying certain positions are required to give "bond" and that bond is in effect an insurance policy. We have also had some experience with compulsory hail insurance, and there is now some compulsory insurance for bank deposits and building and loan savings. These are not, however, considered to be social insurance.

Premiums Paid by Others Than the Insured. A fourth difference has to do with the source of the money with which premiums are paid. In ordinary insurance, the person receiving the protection usually pays the entire premium. Thus normally a property owner insures himself against the financial loss that would result if a fire destroyed or damaged his property, and he pays the entire premium. A policy can also be purchased by a nonowner having an "insurable interest" in the property, i.e., one who would suffer a financial loss if it burned. He would pay the premium and would be reimbursed in case of fire.

That is not usually the case in social insurance. It is true that in some instances employers pay the entire premium, as in most American workmen's compensation and unemployment compensation systems. In others, the workers and employers both contribute, as in the Federal Old-Age and Survivors Insurance system. In still other instances the government makes a direct contribution to the premium, as in many foreign systems. In most systems of social insurance, the government contributes indirectly by paying for much or all of the costs of administration. Employers and the public derive substantial indirect advantages from the social insurance they support, but the direct benefits go to the workers. It may well be that through a devious process of shifting the final incidence of most of the premium or tax will be on the covered worker.

Unpredictability of Costs. A fifth difference concerns the predictability of costs, which are uncertain in all forms of insurance. Where the basic phenomena involved repeat themselves regularly in time, or where there are marked and generally unvarying trends that indicate the nature and extent of the changes that will take place,

then the future can be predicted reasonably accurately. But those conditions do not usually exist in the fields covered by social insurance. Future mortality, birth, sickness, disability, employment, unemployment, retirement, remarriage, wage, interest, and other pertinent rates are all uncertain, some to a greater degree than others. The cost of insurance depends on such rates. Actuaries do their best to estimate what the situations will be at various times in the future, but their estimates are at best subject to substantial margins of error.

The cost of commercial insurance can generally be predicted more accurately than that of social insurance. This is true in part because commercial insurance does not cover the hazards where predictability is most uncertain, such as unemployment. It is true in part also because commercial insurance introduces rigid limitations on its liabilities. For example, private insurance companies will sell a retirement annuity beginning at age 65. The premium will be a specified number of dollars per year, irrespective of the wages or salary of the purchaser. The annuity will begin at age 65 whether the purchaser continues in employment or not. Commercial rates frequently have tolerances, which in life insurance, for example, are said to be about 25 or 30 percent. Should experience be less favorable than expected, dividends can be reduced, and they can be increased if experience is more favorable.

Social insurance is different. Benefit payments in unemployment compensation, for example, depend on the volume of unemployment, and because future pay rolls and unemployment cannot be predicted with any reasonable degree of accuracy, the cost is highly uncertain. Again, old-age annuities are payable on retirement, and are based on earnings. Neither the earnings on which annuities are based and premiums levied nor the rate of retirement have too much certainty. In social insurance, there is sometimes reasonable doubt as to whether the actual cost will be twice or half the estimated costs, and in some instances the range may be even greater.

Irregularity of Premium Payments. A sixth difference lies in the irregularity to which social insurance premium payments are subject. In ordinary insurance, premium payment dates are specified, and if premiums are not paid on those dates the policies lapse or are impaired. The policies may of course later be reinstated under certain conditions, but there is likely to be an interval when there is no protection. In social insurance, premiums are normally based on

earnings. When there are no earnings, there normally are no premium payments. But protection does not therefore necessarily cease. For in some instances provision is made for continuing protection during periods of unemployment, and in others workers build up rights that carry them for some time. This distinction is real, although it is not too clear-cut. For many commercial insurance policies contain features that prevent their immediate lapse in case of failure to pay the required premium on the due date.

Instability of Premiums and Benefits. A seventh difference may be noted. The premiums charged and the benefits paid by ordinary commercial insurance have become pretty well stabilized, because over the years the operation of the Law of Large Numbers has provided sound actuarial bases upon which to build benefit structures and rates. New kinds of hazards develop, to be sure, and the degree of risk in older hazards changes. New policies thus appear on the market and adjustments in the rates on old hazards are made. In short, changes are made. But those changes are relatively small and they do not generally introduce any element of confusion.

In the field of social insurance, however, it is a different story. For there changes are rapid and not infrequently drastic, especially in the early period of the movement. New forms are introduced and old systems are remodeled. Changes in benefits and conditions of eligibility are even more frequent than changes in rates. Confusion does appear and it tends to persist. These changes and confusion appear because social insurance as an instrument of public policy is always subject to sudden and even drastic change.

Monopolistic Carriers. An eighth difference relates to carriers. In ordinary commercial insurance, the person buying a policy can usually choose from among many different carriers or companies that are competing with one another for the business. Insurance agents are always available to expound the peculiar merits of their respective companies and policies, and they frequently make themselves annoying, if not obnoxious. This competition has on balance been beneficial, for it has unquestionably greatly expanded insurance coverage, both in terms of numbers insured and hazards included, and it has made available such a wide variety of policies that almost any practicable combination of provisions needed or desired can be purchased.

In social insurance, however, a single or monopolistic govern-

mental carrier is the general rule. The Federal government, for example, is the sole carrier for the Old-Age and Survivors Insurance, the Railroad Retirement, and Unemployment Insurance, and civil service retirement systems. All states are carriers for their unemployment compensation, and some states are the sole carriers for their industrial accident insurance.

There are many reasons why this is so and why it is considered by many to be socially desirable. One reason is that since the insurance is compulsory and the workers have low incomes, competitive selling and other costs can and should be eliminated. A second reason is that the public may not consider it desirable that profit should accrue to private individuals or companies in a system designed to benefit workers and made compulsory by the state. A further reason given is that with a monopolistic public carrier there will be more liberal interpretation of the law and more liberal adjudication of claims made under it. However sound or unsound these reasons may be from a strictly financial point of view, the public generally considers them to be sound from the point of view of social policy.

Government Contributions. In other countries, part of the cost of social insurance is borne by government, which commonly pays a part of the premium. When some forms of social insurance are first inaugurated, or later extended to previously uncovered groups, the premium rates charged may be such that persons covered by the schemes throughout their lifetime pay the cost of the benefits received. But older persons newly covered receive considerably more in benefits than they pay in premiums. The difference is paid by government. Thus the young are not penalized.

The benefits paid by social insurance schemes are weighted in favor of the lowest-income groups. Higher-income groups could be charged the difference, and in some plans they are. But many believe that it is sound social policy for the government to assume that burden, or more accurately for the people as a whole to bear the burden in the form of government contributions. The cost to the government is not altogether an additional one, for it may to some extent relieve government of making other payments, public assistance for example. Some argue that increased productivity will further reduce the burden.

In systems where government contributes, the need for accumulating and maintaining reserves adequate to meet all liabilities is not

great, as is true in commercial insurance, since the systems are backed by the power of taxation. To some extent, this is merely the power to raise contribution rates, especially where comprehensive systems exist, since added government contributions come from the population. Government contributions make for greater flexibility in the matter of rates, and of benefits as well.

In the United States, government contributions to social insurance schemes are not the rule, except in systems covering government employees. But we are moving in that direction, and it appears to be only a matter of time before the practice will be widespread. The basic compelling reason is that liabilities to pay promised benefits are accruing more rapidly than the means of paying for them, and it does not appear to be politically expedient or socially desirable to reduce benefits or to legislate the necessary rates.

These are the major differences between social and commercial insurance, and they are important. Yet they should not be permitted to obscure the fundamental fact that social and private insurance have much in common. It must always be borne in mind that much of private insurance is designed to do the same things that social insurance does, and that all of it is subject to more thorough government control than any other kind of private enterprise, and this in order to protect the public against incompetence and dishonesty and because of the need to maintain public confidence in insurance. Private insurance is thus quasi-public in nature, and it "lingers in that twilight zone that separates public from private business."

OBJECTIVES OF A SOCIAL INSURANCE SYSTEM

The pattern that should be assumed by any social movement is a matter of personal opinion or conviction, and every man can say that his particular pattern is the best, although in this country no one need agree with him. There are many different views concerning what a social security or a social insurance program should be. One excellent summary statement of what should be the objectives of a satisfactory social security program, irrespective of why such a program might be wanted, has been made by Eveline Burns, one of the leading students of the movement.⁴ That statement is applic-

⁴ In Seymour Harris (ed.), *Economic Reconstruction*, McGraw-Hill Book Company, Inc., 1945, p. 382.

able to the social insurance segment of the broad social security program.

Assure Basic Economic Security. One of the objectives is to "assure basic economic security against all the more common interruptions of private income." Unemployment, occupational and non-occupational disability, and old age are the major common causes of the interruption of private income experienced by those receiving income from personal efforts in the labor market. Persons receiving income in the form of royalties, dividends, interest, and annuities may find that income interrupted as a result of such phenomena as depressions, natural catastrophes, and bankruptcies, but they are not generally considered to be among the classes of people who should be protected by a social insurance system. Public assistance is available to those of them who come to be in need.

It is not clear just what constitutes "basic economic security." In general it may be taken to mean a minimum of subsistence, but the content of that "minimum" is not very definite. It may be a national minimum or one defined primarily in terms of local customs and conditions, and would no doubt depend to an appreciable extent on the size of the national and local income. More will be said later on this subject and on some of the problems involved.

Preserve Important Values. A second objective is "to preserve to the greatest possible degree other important values in our society, and notably it should interfere as little as possible with the influences encouraging initiative." The problem here is partly economic and partly moral. Many believe that social insurance benefits paid as a right will help preserve a feeling of self-respect among those who because of some catastrophe lose their income. On the other hand, if insurance payments are too high, there is danger that some of the recipients may prefer them to wages.

Yield Useful Economic By-Products. A third objective is that a system of social insurance should "yield the greatest possible number of useful economic by-products, implementing rather than running counter to, other accepted social and economic policies." The major problem involved in this objective is that of developing a financial structure that will contribute to the stabilization of the economy rather than exaggerate its characteristic upward and downward movements. The financial structure and operation of a social insurance system should, according to this objective, be in-

tegrated as fully as possible with the country's broad economic policies and specifically with whatever plans for a compensatory fiscal policy the government may have developed.

The realization of these objectives, it will be noted, does not require that all interruptions to private income be insured against, or that all other important values be preserved, or that the social insurance system be subordinated altogether to general stabilization programs. Social insurance is believed to have a place of its own, not irrespective of other considerations, but in relation to other considerations and objectives.

PART TWO

OLD AGE

CHAPTER TWO

THE PROBLEM OF OLD AGE

DESPITE the panegyrics that have been written about it, old age has been a time of sorrow and tragedy for too many people, especially in Western civilizations. Most people have not, for one reason or another, reached old age, "the last of life, for which the first was made," with incomes or capital sufficient to support themselves in peace and dignity. Their lot has been one of dependency upon others for all or for a part of their support, usually upon their children who are themselves struggling to secure a firm and lasting foothold in life. They learn, as did Dante, how bitter is the taste of others' bread and how hard the going up and down another's stairs. For those who support them do not generally consider it a privilege to bear that burden. Indeed, many shirk what once was generally thought to be a bounden duty. Only the most fortunate die "in harness" or accumulate a competence sufficient to enable them to retire and to remain the masters of their soul.

Old-age dependency is not a modern industrial phenomenon, but is found among primitive peoples and was common in ancient times. Apparently it is a phenomenon that in general has become more serious to the dependent as civilization has progressed. Contrary to a fairly popular impression, aged dependents were rarely "knocked on the head and relieved of old-age worries" by primitive peoples. One student of the problem reports that:

Individuals everywhere seem to have become progressively dependent upon others for their food with the onset of old age. The assurance of food from a group or communal source has not been entirely lacking in the simplest known societies. In fact, it appears that customs of sharing food with the aged have been strongest in the very harsh and difficult environments, when the food supply has been less constant, and where types of maintenance have been less well developed, as among collectors, fishers, and hunters. With advance to herding and agriculture, and the develop-

ment of cultural traits characteristic of "higher" civilization . . . support of the aged through communal sharing of food appears to have declined in importance or to have taken on features characteristic of "organized charity."¹

AGED PERSONS IN THE ECONOMY

In a society where few people reached old age or where those who did so either continued to work in employment yielding a good income or retired on a substantial and secure competence, the problem of old age would not be seriously complicated by economic factors. But ours is not such a society.

Growth in the Number of Aged. A striking fact, over which many have expressed grave concern, is that the proportion of older persons in our population has for many decades steadily increased and that it will continue for some time to do so. As a people, we are now rapidly approaching physical maturity. Table 1 presents figures showing conclusively that this is true. The proportion of those 65 and over rose from 4.1 percent in 1900 to 8.0 percent in 1950. It has been estimated that by 1970 the proportion of those 65 and over will be 10.1 and that it will be 12.7 by the year 2000, which is the maximum expected. The recent increase in birth rates runs counter to the anticipated trend and will reduce the proportion of the total population which is 65 and over. The upward trend will be slowed down to some extent, but not greatly and not for long.

TABLE 1. Percentage of the Total Population 14 Years and Under and 65 Years and Over, for Specified Years

Year	Percentage of Total Population	
	14 and Under	65 and Over
1900	34.4	4.1
1910	32.1	4.3
1920	31.8	4.7
1930	29.4	5.4
1940	25.1	6.8
1950	27.0	8.0

The magnitude of the problem of old-age dependency varies directly with the absolute numbers involved. The increasing per-

¹ Leo W. Simmons, *The Role of the Aged in Primitive Society*, Yale University Press, 1945, pp. 34-35.

centages of aged persons applied to a steadily growing total population have yielded marked increases in the absolute number of aged persons in this country. In 1900 there were 3 million persons 65 years or older. By 1920 the number had increased to nearly 5 million, and to 6.6 million by 1930. There were approximately 8 million in 1940, and at the end of 1950 there were roughly 12.2 million. It has been estimated on the basis of present mortality trends that there may be approximately 18 million in the year 1960. The yearly increase at present is approximately 200,000, but decreasing mortality rates will raise that figure substantially.

Several factors account for the increasing proportion of aged persons in the total population. The most important one appears to be the decline in the birth rate, which reduced the proportion of children in the total population and thus automatically increased the proportions in the older-age groups. The number of live white births per thousand of total population in 1796-1800 was about 55, for 1896-1900 it was about 30, while it was less than 17 in 1933. A slight increase occurred after 1933, and a marked increase during the war and immediate postwar years, but there is no reason to suppose that the downward trend has been permanently checked. Indeed, the decline will most certainly be resumed and will continue for many decades, although for how many decades no one knows.

In 1900, those 14 years of age and under constituted 34.4 percent of the total population, while in 1950 they constituted only 27.0 percent, as reference to Table 1 will show. Medical science has done, and is continuing to do, much to make childbearing easier and safer, and it has prolonged to a remarkable extent the average life of children and young people. The decline in death rates among children has accentuated the increase in the proportion of older persons, since more of those born have lived to middle and old age. Approximately 30 percent of those now 65 or older are said to owe their survival to modern medicine, public health activities, and general welfare services. It should be added that economic progress has made its contribution also. The quantity, quality, and variety of food, clothing, and shelter have greatly increased. Furthermore, much less time is spent on the job and considerably more in schools, at play, and at rest.

Until recently, medical science did little to prolong the lives of those 65 and over. The median age of persons 65 years of age and over remained almost constant—about 71.2 for men and 71.6 for

women—from 1870 to 1940, as contrasted with an increase from 20 years in 1870 to 29 years in 1940 for the entire population. The diseases of old age are hard to combat. Furthermore, the medical care of the aged has until quite recently been neglected, and the medical profession is said by some to have shown “an amazing ignorance of their needs.”² Since 1936, however, and largely because of the sulfa drugs and antibiotics, there has been a marked reduction in the mortality rates for persons 65 to 84, more so for women than for men.

Surprisingly enough, the increasing complexity, speed, and strain of modern social and economic activity do not appear to have had any serious adverse effect on the span of life. Those reaching the older-age levels seem to live on, in terms of years, about as they did in simpler times, but in larger proportions than in primitive times. It is reported that “a few individuals even in very primitive societies live to about as great age as in modern civilization,” but that “they may be regarded as exceptions to the rule of a relatively limited span of life and perhaps an early onset of old age.”³

One reason for the marked increase in the percentage of older persons from 1930 to 1950 is the reduction in immigration resulting from our change of policy. Immigrants are relatively young persons, and until recently they came to this country in large numbers. Their coming increased the proportion of the middle-aged groups and therefore tended to slow down the percentage increase among those 65 and over. Until 1832, the average annual number of persons admitted to this country was small, amounting to only a few thousands. It then increased appreciably, and for 15 years averaged about 77,500. During the period 1903–1914 the annual average reached a peak of almost 1 million. Restrictive legislation reduced the number appreciably after 1924, and more recent restrictive legislation has practically eliminated immigration. For 10 years before World War II, the average annual number admitted amounted to only 50,000, and to 30,000 during the war. It is not likely that our immigration policy will be changed sufficiently to permit large-scale resumption of immigration, at least not in the near future.

Modern industry has provided a substantial portion of the means

² Malford W. Thewles, *Care of the Aged*, C. V. Mosby Co., 5th ed., 1946, pp. 22–23.

³ Leo W. Simmons, *op. cit.*, p. 16. Life expectancy at birth in the Roman Empire was about 23 years; in 1850 in New England it was 40 years; in the U.S. in 1900, it was 47; in 1930 it was about 60 for whites; and in 1940 it was about 65 for whites.

by which the average length of life has been extended. Yet in a sense it has had an adverse effect on the longevity of workers engaged in it. Death rates for industrial workers have been higher than for non-industrial workers and higher than for the population as a whole, except that for workers 15-24 and 65 years and over the rates are lower than for those age groups in the general population.

For the Metropolitan Life Insurance Company's white male industrial policyholders, death rates per 100,000 of those 65 and over declined from 9109.4 in 1912 to 6569.3 in 1938, a decline of 27.9 percent.⁴ Life expectancy at age 20 in 1912 was about six years less for white males than for the same age in the general population, but by 1939 the difference had been reduced to two years. In 1947 the gap was closed. Lower mortality rates among industrial workers are likely to mean higher dependency rates among the aged.

Gainfully Occupied. The percentage of the total population reported gainfully occupied or in the labor force has steadily increased over many decades. The terms "gainfully occupied" and "labor force" do not have exactly the same meaning, but no distinction will be made between them here. The labor force consists of all persons working for money or seeking jobs in which money is earned. The percentage gainfully occupied went up from 44.3 of those 10 years and over in 1870 to 49.5 in 1930. In June of 1951, there were 63.8 million in the civilian labor force, 2 million of whom were unemployed. This increase has continued despite the great decline that has taken place in the employment of children. The number under 15 years in the labor force is now negligible.

But the percentage of older persons reported as being gainfully occupied or in the labor force has steadily declined for decades. Table 2, based on census data, gives numbers and percentages by decades from 1870 to 1940, and for 1947.

The percentage of men 65 and over who were gainfully occupied or in the labor force declined from an estimated 80.6 in 1870 to 41.5 in 1940, and then increased to 48.4 in 1947. For women, the movement has been erratic and the changes less marked. The sharp percentage declines from 1930 to 1940 may be accounted for in part by overstatement of ages in 1940 and understatement in 1930, and by an underenumeration of the aged in the labor market in 1940. It is probable that many able-bodied older persons in 1940 had

⁴ Louis I. Dublin and Robert J. Vane, "Occupational Mortality Experience of Insured Wage Earners," *Monthly Labor Review*, June 1947, p. 1004.

no hope or expectation of getting work and reported themselves retired. Statistics on the employment status of older persons are not as reliable or as meaningful as those on younger persons, because it is difficult for enumerators to distinguish between able-bodied persons seeking work and disabled and retired aged persons no longer in the labor market. The total number of aged men and women involved increased steadily from 515,000 in 1870 to 2,201,000 in 1930, declined slightly to 2,097,000 in 1940.

TABLE 2. Men and Women 65 Years of Age and Over Who Were Gainfully Occupied or in the Labor Force in the United States, 1870-1947 ⁵

Year	Aged Persons Gainfully Occupied or in the Labor Force			
	Number (in Thousands)		Percent of Aged Population ^a	
	Men	Women	Men	Women
1870 ^b	481	34	80.6	5.8
1880 ^b	665	50	76.7	5.8
1890	911	91	73.8	7.7
1900	1064	129	68.4	8.5
1910	1266	168	63.7	8.6
1920	1494	192	60.2	7.9
1930	1939	262	58.3	7.9
1940	1829	268	41.5	5.8
1947	2390	435 ^c	48.4	8.0

^a 1870-1930 data are for gainfully occupied; 1940 and 1947 data relate to the labor force. Excludes unpaid female family workers.

^b Percentages were estimated from trend lines, and applied to population of men and women 65 years of age and over. The 1870 population was corrected for underenumeration.

^c Assuming 5000 unpaid family workers.

There is no doubt that the percentage of those 65 and over gainfully occupied or in the labor force has steadily declined. But a different approach to the problem has yielded estimates differing markedly from the figures given above.⁶ The method used in this approach is described as follows:

For each of the census years 1870-1940 the proportion of aged men to all men gainfully occupied (or in the labor force) was computed separately for agricultural and nonagricultural pursuits. These two percentages

⁵ S. J. Mushkin and Alan Berman, "Factors Influencing Trends in Employment of the Aged," *Social Security Bulletin*, August 1947, p. 19.

⁶ *Ibid.*, p. 20.

for each census year were then applied respectively to modified figures for all males in agricultural and nonagricultural classifications. (The modified agricultural gainfully occupied figures were based on the percentage of the total male population engaged in agriculture in 1940 applied to the various total male populations of each census year. Then the modified figures for the nonagricultural gainfully occupied were obtained by subtracting the derived modified figure for agricultural gainfully occupied from the reported total gainfully occupied in the census.) The resulting numbers of aged men gainfully occupied in the two categories were added together for each census year and then expressed as percentages of the total aged male population. The same procedure was followed to obtain the percents for the aged women who were estimated to be gainfully occupied. The method used assumes that the proportion of aged persons in agriculture and in nonagricultural industries would be the same as those indicated by each census despite the assumed 1940 distribution between industry and agriculture for each census year of employment.

Application of this method of analysis yielded the following estimates of the percentages of persons 65 and over gainfully occupied or in the labor force:

Year	Men	Women
1870	58.7	7.2
1880	56.6	6.3
1890	62.1	6.5
1900	60.2	6.8
1910	56.8	7.5
1920	56.2	6.6
1930	56.1	7.4
1940	41.5	5.8

These estimates also show declining trends, but the declines are not as marked as those shown in the previous figures, especially for men, who constitute the bulk of those in the labor force. There is still a marked decline from 1930 to 1940, which cannot be explained very satisfactorily, and which is probably exaggerated.

During the late war, the percentage of older persons employed increased. In December of 1945, a total of 2,930,000 were estimated to be in the labor force, which would amount to approximately 29 percent of the total number of those 65 or over. The employment of aged men was about 25 percent above "normal," and the percentage for aged women was almost 50 percent above normal. The trend was reversed after the cessation of hostilities, and this is reflected in the marked additions made to retirement and old-age assistance rolls.

But in April of 1947, the employment of aged men was still about 25 percent above normal, and the excess of women had been reduced to only 29 percent.⁷

Many factors influence the employment of older persons, such as their age, state of health, extent and nature of industry, economic necessity, union seniority rules, protective legislation, social and psychological attitudes, and availability of pensions and old-age assistance.⁸

It is not clear to what extent older persons who are not in the labor market have been deliberately forced out of employment on account of age or other factors and to what extent they have voluntarily retired from, or have never been a part of, the labor market. Relatively few people in this country, except housewives, grow up without becoming attached to the labor market in one way or another. The "idle rich" who have inherited their competence and spend their time in play are conspicuous enough to attract some attention, but they have never constituted a significantly large class in this country.

American wealth and income have increased more rapidly than has total population, much more rapidly even than our older population. That increase in wealth and income has made it possible for many to retire on their own savings who otherwise might have remained in the labor market. Such meager data as we have on this subject, however, suggest that income from real and personal property supports a relatively small proportion of all the aged, perhaps not more than one-third. Some are supported in their old age by pensions and annuities. But more about this later.

A recent sample study, of 2380 old-age insurance beneficiaries, showed that more than 50 percent had been laid off, about one-third quit because of poor health, and only about 5 percent had voluntarily retired in good health. But this was probably not typical of times before the Federal Old-Age and Survivors Insurance system was established. The average age at retirement under that system is approximately 67 years, retired beneficiaries under that system average four years younger than recipients of gratuitous old-age assistance, and three years older than the aged in the general popula-

⁷ Ewan Clague, "Employment Problems of the Older Worker," *Monthly Labor Review*, December 1947, pp. 661-663. Mr. Clague takes a gloomy view of the industrial future of aged workers.

⁸ S. J. Mushkin and Alan Berman, *loc. cit.*, pp. 20-21.

tion.⁹ The time comes under any system when older persons are no longer able to work, or to work with the required efficiency. And since most workers, and many corporation executives and professional men as well, do not accumulate enough to support themselves in retirement, they do not quit in large numbers and must inevitably be laid off.

Waning Employment Opportunities. Much has been said in recent years about the waning opportunities for older workers in industry, and the figures just cited show conclusively that relatively fewer of the aged population are gainfully occupied.

Modern industry has its maximum-hiring-age limits and these have aroused considerable resentment. Firms which admit that they have such limits employ from 30 to 40 percent of all nonagricultural workers, and the most common maximum-hiring-age limits are 45 for unskilled and 50 for skilled workers.

Older workers are said to be generally less adaptable than younger ones and sometimes the skill and experience acquired in their youth make it more difficult for them to adjust to new methods and processes. Frequently they object to being supervised by younger men. They are generally considered to be greater accident risks, both to themselves and to others. They themselves experience relatively fewer injuries than younger persons, but those are more serious. Insurance premiums for industrial accident compensation, sickness and hospital insurance, life insurance, and private pensions are higher where a substantial proportion of the workers are in the upper-age brackets. These factors, and others that are similar, all reduce down to the basic fact that it is generally less profitable to employ older persons, or at least that many employers think it is less profitable.

Many, perhaps most, of those who have been most anxious to increase employment opportunities for the older worker have been dominated by the "salvage" rather than by the profit point of view.¹⁰ But an increasing number of students are now showing by careful

⁹ Jacob Fisher, "Aged Beneficiaries, Assistance Recipients, and the Aged in the General Population," *Social Security Bulletin*, June 1946, p. 11.

¹⁰ That point of view is well expressed by one doctor as follows: "... the process of physical and mental deterioration is hastened in many older people as a result of the psychologic shock that comes with the realization that their usefulness is over. In addition to the difficult problem of keeping them occupied, their families may then be burdened with the actual expense of their upkeep." Wingate M. Johnson, *Geriatrics*, vol. II, No. 5, September-October 1947, p. 266.

research that it is profitable to employ older workers, especially in certain types of work where their stability, loyalty, and responsibility make them valuable assets. It is being shown that many of the reasons given for not employing older persons have little or no validity.¹¹

There are reasons other than profits, however, for hiring-age limits. Some employers set such limits in order to protect the jobs of older workers already in their employ, whom they could displace with younger persons if they wished to do so. Some make a practice of hiring younger workers and training and promoting their older employees to better jobs. To be sure, these practices may well increase profits, and it is reasonable to suppose that employers are aware of that fact. But there is evidence that many employers have borne heavy burdens to care for their aged workers. Indeed, one argument made for private pensions and also for old-age assistance has been that they would enable employers to retire their less efficient older workers and thus reduce their costs.¹²

Yet it must be pointed out that the percentage of persons in each of the major occupational divisions of our economic life who were 65 years of age or over has increased for decades, for all occupations combined and for each major division except professional service. There has been a great increase in the number of persons engaged in professional work, and the source of supply has been young men and women trained in our institutions of higher learning. When employment in the professions becomes more stabilized, those 65 and over will constitute an increased proportion of the total. Table 3 shows the increase in the employment of older persons by decades and for the year 1947.

It can hardly be maintained that young people are crowding older people out of employment. The percentage of men gainfully occupied or in the labor force who were 65 or over fluctuated somewhat from 1870 to 1947, but the trend was slightly upward. For women the trend was certainly not downward, although the movement was somewhat more erratic.

¹¹ See Ross A. McFarland, "The Older Worker in Industry," *Harvard Business Review*, Summer 1943, pp. 505-520; Michael T. Wermel and Selma Gelbaum, "Work and Retirement in Old Age," *The American Journal of Sociology*, July 1945, pp. 16-21; Henry W. Steinhaus, *Financing Old Age*, National Industrial Conference Board, 1948, pp. 49-53.

¹² Abraham Epstein, *The Challenge of the Aged*, The Vanguard Press, 1928, pp. 142-143.

TABLE 3. Percent of Total Population Gainfully Occupied or in the Labor Force and Percent of Gainfully Occupied or in the Labor Force, 65 Years of Age and Over, by Sex, for the United States, by Decennial Years, 1870-1940 and 1947 ¹³

Year	Percent of Total Population Gainfully Occupied or in the Labor Force		Percent of Gainfully Occupied or in the Labor Force, 65 Years of Age or Over	
	Men	Women	Men	Women
1870	54.7	7 5	4.4	2.3
1880	57 8	8 4	4 5	2.4
1890	60 2	11 3	4 7	2.7
1900	61 2	12 4	4 5	2 6
1910	63.2	14 9	4 2	2 5
1920	62 7	15 4	4 4	2.4
1930	61.3	16 9	5 1	2.6
1940 ^a	60 5	18.9	4 6	2.2
1947 ^b	60 4	21 6	5 6	2.8

^a Represents percentage of total population in the labor force and of labor force 65 years of age and over

^b Same as footnote *a* except that labor-force data apply to civilians only.

Of those gainfully occupied, then, there are relatively more who are older men and women today than before. And since the total number gainfully occupied has increased steadily, it follows that the absolute number of persons 65 and over has also increased. However, the increase in the employment of the aged has not kept pace with the total increase of those 65 and over, and this fact is reflected in the figures given above showing a marked decline in the percentage of those 65 and over who are gainfully occupied or in the labor force.

There appears to be relatively little in present occupational trends that would justify the gloomy predictions heard on all sides that the older worker is doomed to play a vanishing role in our economy. At the moment there is a relative decline in the importance of the professions, but that appears to be temporary. Relative declines in skilled and sales occupations may be permanent. The service occupations are on the upgrade, and older workers are useful there. It may be worth while to quote a brief conclusion reached by one student of the problem. He says: "The main direction of the trends is toward the requirement of larger numbers of well-trained workers. The

¹³ S. J. Mushkin and Alan Berman, *loc. cit.*, p. 20.

greatest declines are taking place in occupations which require the least training. Furthermore, occupational outlook studies made by the Bureau of Labor Statistics lead overwhelmingly to the conclusion that in many fields workers will be required to have better educational preparation."¹⁴

Surely in that kind of an economy, the older worker will have a place, and in some respects an advantage. It would seem reasonable to say that the employment future of older workers appears to be bright, rather than gloomy. If older workers cannot find employment, their future and that of the younger workers who will have to support them will indeed be gloomy.

Unemployment Among the Aged. In a dynamic capitalistic economy, there is always some involuntary unemployment and at times there is a great deal of it. The total burden is unequally distributed as between time, region, occupation, color, sex, and age. Information regarding the distribution on any basis is generally scanty. Only scattered fragments of information on unemployment according to age are available, most of them for the period of the Great Depression, and the information is none too comparable or reliable.

During the depression of 1929-1939, unemployment was greatest among those in the age group 15-19 years. By this is meant that the percentage unemployed among those 15-19 in the labor market was higher than comparable percentages for any other age group. The percentage unemployed ranged from 39 to 70 at different times and in different places.¹⁵ Most of the surveys and censuses showed the next highest percentage to be among the age group 20-24. Youngsters just coming into the labor market found few openings, and those who had jobs were laid off in large numbers because they were less valuable and had fewer family obligations. Next to these two came the age group 65 and over, in nearly all of the censuses. For these older workers, the percentage unemployed ranged from 19 to 53.

It does not follow, however, that older workers were laid off in relatively larger numbers than others except those under 24. The percentage of any age group considered unemployed is the ratio

¹⁴ Harold Goldstein, "The Changing Occupational Structure," *Monthly Labor Review*, December 1947, p. 654.

¹⁵ For figures on unemployment by age groups, see W. S. Woytinski, *Three Aspects of Labor Dynamics*, Social Science Research Council, 1942, especially chaps. xii-xvi. Also Richard A. Lester, *Economics of Labor*, The Macmillan Company, 1941, p. 375.

of those in that age group who are seeking work to the total number of that age group who are seeking work plus the number employed. Those seeking work consist of the ones laid off plus any others who for whatever reason are out looking for work. During the depression, many older persons who had retired or who had never been in the labor market found it necessary or desirable to seek employment. That was true of the youngest unemployed as well. The largest "reserves" of male labor are in the extreme-age groups, but female reserves exist in large numbers in all age groups.

How many aged persons returned to the labor market during the depression years is not known. The census of 1930 reported about 2.2 million persons 65 or over "gainfully occupied," i.e., either employed or seeking work.¹⁶ By 1935, there were perhaps as many as 3 million. It has been estimated that in April of 1945, the excess above normal of persons 65 and over in the labor force was 590,000.¹⁷ Patriotism and the pull of high earnings may have been more potent factors than the financial need experienced by many of the aged during the depression. Yet it does not seem unreasonable to suppose that during the depression years the number of unemployed aged persons, the number looking for work, was swelled by a substantial number not normally in the labor market. If due allowance were made for these aged persons, the percentage of those 65 and over unemployed during the depression would be materially reduced. The net result would be more uniformity in the rates of unemployment among different age groups.

Available data do not make it possible to trace a full and clear pattern of the volume and variation in unemployment among the aged. But they do indicate that the volume is both absolutely and relatively large. This conclusion is not surprising, but it is significant because it provides substantial support to the movement for insurance and assistance benefits.

CAUSES OF OLD-AGE DEPENDENCY

There are many reasons why, or ways in which, old persons become dependent upon others in societies where the distribution of nearly all goods and services is through the money and credit

¹⁶ W. S. Woytinski, *Labor in the United States*, Social Science Research Council, 1938, chaps. v and vi.

¹⁷ *Monthly Labor Review*, November 1945, p. 843.

mechanism, and where the general store and regular flow of those goods and services are available only to those who have money. In our society, nearly all persons depend for their maintenance on money income, and especially so in cities. In 1940, more than half of our urban families were reported as receiving their entire income from wages and salaries. The number of such families was 11.1 million, and constituted nearly a third of all the families in this country. Most of the others received the major portion of their income in the form of wages and salaries. Slightly less than 60 percent of all families were urban.¹⁸ We are becoming still more urbanized.

Low Earnings. Despite our exceptional resources, industry, and ability, a surprisingly large proportion of persons receive small incomes, and many never earn enough to provide for their declining years. It is hardly necessary to review the statistics here. But it might be well to point out that average weekly earnings in manufacturing were under \$20 from 1932 to 1934, that they were under \$30 until 1941, and exceeded \$40 only beginning in 1942.

Low earnings are mostly accounted for by the lack of skill, capital, or opportunity, by disability resulting from sickness or accidents, unemployment, and in a relatively small number of cases by downright laziness. And for most people, the older they become the more effective are these factors in reducing their earning power. There are in turn many specific causes behind each of these, and other, factors.

Lack of skill is perhaps the most important cause of low earnings. The mass of our working people are relatively unskilled and cannot therefore command large incomes in a labor market where income is fairly closely related to value productivity. Except in times of severe depression, sickness has been the most important single cause why people have sought relief, and has been of material importance in reducing earning power. In this country there have been few periods of widespread and prolonged unemployment. But the period beginning late in 1929 and continuing with varying intensity through 1940 is an exception.

Low earnings are by no means restricted to wage earners and small independent businessmen. "All executives are not highly paid and do not have substantial reserves. The average executive, like the

¹⁸ Old people are distributed between urban and rural areas in about the same percentages as they represent in the total population. In 1950, some 36 percent of those 65 and over lived in rural areas and half of these lived on farms

average worker or professional man, tends to live up to his income. In addition, he has many responsibilities and in recent years has carried a heavy tax burden.”¹⁹ Negroes and women have suffered considerably from lack of opportunity to earn money. When, for whatever reason, older people are no longer able to work, or to work as effectively, their income is materially reduced or ceases altogether, and substantial numbers of them become dependent upon others.

Many with fair or even good incomes have failed to accumulate a competence because of the heavy burdens borne during their most productive years, such as raising a large family or supporting dependent relatives or both. The dependent aged have themselves contributed somewhat to the later dependency of others, although perhaps more frequently it has been children who have done so. The total burden of caring for older dependents has been to some extent offset by the declining number of children per family, for it costs considerably more to raise children than to care for aged persons.

Most of those who become old and who continue in employment suffer a decrease in earning power. Middle age is generally the period of highest earnings. For most people, employment after age 65 is necessarily at light tasks and low pay. There are important exceptions, however.

Competition for Social Status. Social status is almost as important in modern civilized society as it was in ancient and is in some primitive societies, although with us the lines of demarcation between classes are perhaps not as finely drawn, there is greater fluidity between classes, and pecuniary distinctions play a more significant role. Competition for social status in this country has become severe, because of the enormous variety of goods and services produced, the effective channels for distributing them, and the cunning and abundant salesmanship and advertising used. It might be added that there is a school of economists whose doctrines are erroneously interpreted by the masses as lending support to their desire to spend what they have.

The maintenance of a certain level of living is a practical necessity for most people in virtually all walks of life, and those levels require a substantial part of the incomes of the individuals involved. There has been an almost irresistible tendency for the levels to become ex-

¹⁹ John Calhoun Baker, "Pensions for Executives," *Harvard Business Review*, Spring 1940, pp. 309-310.

cessively high and to include many items representing conspicuous consumption. Competition for social status has led many with substantial incomes to maintain in their productive years levels of living which have left them with little or no margin whatsoever for old age.

Adversity has dogged the heels of many unfortunate men and women, but the *ignis fatuus* of a good time has lured even more to their destruction. Living up to or even somewhat beyond one's means is generally so much fun while it lasts that consideration for old age has been pushed into the background and frequently eliminated altogether. How much this has contributed to dependency, no one knows. But irrefutable evidence is to be seen everywhere, and there is more of it than most social reformers are willing to recognize.

Loss of Savings. Some do accumulate reasonably adequate savings, but frequently those savings for one reason or another become inadequate. We have only estimates of savings for the country as a whole and all of these estimates agree that among the lower-income groups savings are small and that among the lowest-income group they are negative. Total savings deposits in the United States went up from \$8.5 billion in 1913 to \$28.4 billion in 1928, an increase of nearly 300 percent. The average amount per deposit, however, declined from \$757 to \$534. As far as they go, these figures show an increase in total accumulated reserves, and it is perhaps reasonable to suppose that the savings deposits were made mostly by the lower- and medium-income groups. But they do not go far enough, for savings may and do appear, and disappear, in many other forms—such as property and security holdings.

Students of the problem are generally agreed that savings for old age by the lower-income groups have not increased appreciably if at all in recent decades, except perhaps for a short period of time during the recent war. The National Resources Committee reported that for 1935–1936, about 60 percent of 39.5 million households in the United States had incomes of less than \$1250 and on the average not only failed to save, but actually drew on reserves, went into debt, or went on relief. Households with annual incomes of \$1250–\$1500 saved at the rate of 2 percent of income. Higher-income households saved more. Substantial savings were made by only about 4 million households. Those years, it will be recalled, were dark ones in the great depression.

During the late war, both income and savings were appreciably higher. It has been estimated that net savings of individuals in-

creased from \$6.0 billion in 1939 to \$38.9 billion in 1944, and declined to \$34.7 billion in 1945. Those savings were substantially dissipated in later years by inflation.²⁰

The accumulation of savings, even if the savings are adequate at the time of their accumulation, does not assure continued independency in old age. For accumulated savings are frequently lost, in whole or in part, because of contingencies over which the individuals concerned have no control.

Price increases, or the decline in the value of money, have frequently reduced the purchasing power of accumulated savings. In 1913, the cost of living index of the United States Bureau of Labor Statistics was 57.4, based on 100 for 1923-1925. By June of 1928, it had risen to 99.2, thus reducing the purchasing power of accumulated savings considerably, except those invested in property or securities whose earning power correspondingly increased. Price increases since 1933 have had the same effect. Decreases in prices have the opposite effect, but in recent years the general trend in prices has been upward.

Bank failures have in the past wiped out the savings of many people. The present Federal Deposit Insurance system has largely, but not altogether, eliminated the loss of savings in the form of bank deposits, and deposits or savings in building and loan associations as well, especially those of small depositors.

Business failures have also reduced many to the status of dependency, especially among the small businessmen whose entire capital is invested in the business. The number of such failures is normally fairly large. During depressions, it becomes abnormally large. The Great Depression beginning in 1929 wiped out or materially reduced the capital of millions of persons. Changes in technology and in consumers' demand, and geographical shifts in industries have also wiped out or reduced savings in many cases.

Other catastrophes have contributed their share to the relief rolls. Fires, earthquakes, floods, tornados, explosions, etc., occur constantly, destroying property and earning power. It is true that some of the loss occasioned is covered by insurance, but much of it is not.

The number of widows and others who have been swindled of

²⁰ W. S. Woytinski, "Postwar Economic Perspectives, IV, Aftermath of the War," *Social Security Bulletin*, March 1946, pp. 19-20; Murray W. Latimer, *Guaranteed Wages*, Office of War Mobilization and Reconversion, 1947, p. 188, Table No. 3.

their savings has been exaggerated, perhaps even grossly so. But no one will deny that this is a serious and persistent phenomenon in our society. Because of it, many become dependent.

EXTENT OF OLD-AGE DEPENDENCY

Much has been written about the pitiful and even tragic conditions of those who reach old age without having accumulated enough for their support. No one can deny the evidence that lies nearly everywhere in abundance. Yet comprehensive data on the extent of old-age dependency in the United States as a whole simply do not exist, although numerous local surveys and national estimates have been made.

A Wisconsin survey of 1915 showed 47.1 percent of the population 60 years or over had less than \$300 annual income, and a Connecticut survey of 1932 showed 9.2 percent of those 65 or over had less than \$300 annual income. Few had property of any substantial value. For New York State in July of 1929, an estimate was made that 56.4 percent of those 65 or over were dependent. A study showed that in 1934, 48 percent of those 65 or over in the District of Columbia were dependent.²¹

The national estimate for 1937 (see page 45) shows the means of support of 7,816,000 persons 65 years of age or over in the United States early in that year. It gives the number of self-dependent and dependent, and the percentages which they bear to the total.²²

More than 5 million persons 65 and over were estimated to be wholly or partially dependent, and nearly 1.4 million of these were on Federal relief programs. Organized private charity was doing exceedingly little to care for the aged, almost nothing in fact. More than 140,000 were in public homes or public institutions of some kind, but relatively few have ever gone "over the hill to the poor-house." Friends and relatives, mostly self-dependent husbands, bore the brunt of the burden, caring for nearly 3.5 million. Just how heavy the burden was is not known, for the estimates do not indicate to what extent the 5 million were only partially dependent. To be sure, 1937 was not a good year, although it was much better than the few years preceding it, and one may well question whether all those on

²¹ *Social Security in America*, Social Security Board, 1937, pp. 149-152.

²² Marjorie Shearon, "Economic Status of the Aged," *Social Security Bulletin*, March 1938, p. 6, and August 1938, note, p. 7.

relief actually needed it. But even after making all reasonable allowances, the number of dependent aged was still large, sufficiently so to cause concern.

1. Self-dependent	2,746,000	35.1
a. Current income from earnings, savings, real estate and securities	2,172,000	27.8
b. Federal pensions	104,000	1.4
c. State and local pensions	66,000	0.8
d. Private pensions	175,000	2.2
e. Trade union pensions	10,000	0.1
f. Insurance annuities	204,000	2.6
g. Other resources	15,000	0.2
2. Dependent, wholly or partially	5,070,000	64.9
a. On Federal programs	1,374,000	17.7
b. Organized private charity	10,000	0.1
c. Public homes and institutions	141,000	1.7
d. Private homes for the aged	55,000	0.7
e. Other	10,000	0.1
f. Friends and relatives	3,480,000	44.6

A study made early in 1943 of 6 million retired persons 65 years or over showed that 2,475,000, slightly more than 41 percent, depended upon voluntary assistance from lodge, church, or family for their living. Others were receiving governmental or institutional aid. Altogether, approximately half of the total were found to be dependent.²³ Since there were somewhat fewer than 10 million persons 65 or over, this represents approximately one-third of the total. Of the others, 1 million, or 16.6 percent, were supported by military and civil service pensions, 525,000, or 8.7 percent, by private insurance annuities, 350,000, or 5.8 percent, by Federal Old-Age and Survivors Insurance benefits, and 1,150,000, or 19.1 percent, by income from basic resources such as real estate, securities, and bank accounts.

A somewhat different, unofficial, approach to the problem of the extent of old-age dependency was made by the Social Security Board. It gives unofficial and preliminary estimates of the numbers of persons 65 or over who on June 30, 1945 received their most significant income from certain specified sources.²⁴

It was estimated that of the 10.1 million persons 65 or over, 33.7

²³ W. R. Williamson, Research Council for Economic Security, *Publication No. 8*, p. 42.

²⁴ *Issues in Social Security*, A Report to the House Ways and Means Committee, 79th Congress, 1st Sess., pp 267-271.

percent, or 3.41 million, received their most significant income or support from the labor market. Of these, 19.8 percent received their most significant income or support in the form of remuneration for employment, 13.8 percent as earnings from self-employment, and 0.1 percent from benefits based on temporary nonemployment, such as unemployment compensation, the Rhode Island sickness insurance system, and sick pay from employers. Pensions were the most significant source for 17.8 percent, 11 percent of these being from governmental pensions, and 6.8 percent from private retirement systems, individual annuity contracts, and informal nongovernmental pension arrangements.

Assistance was the most significant income or support for 38.8 percent, or 3.93 million. Of these, 20.4 percent were on governmental noninstitutional assistance, and 16.3 percent on private assistance, all but 0.5 percent being aid from friends and relatives. Only 2.1 percent were estimated to be receiving institutional care. Table 4 gives some more current data that throw a bit of light on the problem.²⁵

TABLE 4. Estimated Number of Persons Aged 65 and Over Receiving Income from Specified Source, December 1946
(In Millions)

Source of Income	Total	Men	Women
Total	10.5	5.0	5.5
Employment	3.6	2.3	1.3
Earners	2.7	2.3	0.4
Wives of earners	0.9		0.9
Social insurance and related programs	1.7	1.1	0.6
Old-age and survivors insurance ^a	1.1	0.6	0.4
Other ^b	0.7	0.5	0.2
Old-age assistance	2.2	1.1	0.1
Institutional care	0.2	0.1	0.1
Other	^c	^c	^c

^a Persons receiving primary, wife's, widow's, and parent's benefits.

^b Railroad, Federal civil service, and State and local government retirement systems, and veterans' program

^c The number of persons not in institutions with income from sources other than those specified, or with no income, is unknown, since some persons received income from more than one source shown

Any conclusion based on national estimates and regional surveys, however carefully they have been done, must be accepted with considerable reserve. However, it seems reasonable to conclude that

²⁵ *Social Security Yearbook*, 1946, p. 2, Table 3.

probably approximately one-third of the persons 65 or over are almost wholly dependent upon others for their support, and that in addition a substantial number are partially dependent.

It is possible that, as most people believe, the proportion of the aged who are dependent has increased, especially in the past fifty or one hundred years. It is probable that more are wholly dependent. No one knows how much partial dependency there is now or how much there was in earlier times on farms and in small towns. The total amount of aged dependency may be no greater, although the burden has become more concentrated, more visible, and more amenable to statistical treatment. But it is certain that an increasing percentage are not being supported by their friends or relatives.

Whether the total burden be increasing or not, it is true that a substantial number of people reach old age without adequate means of support. They must be cared for. Old-age assistance is therefore necessary and justifiable. But in order to reduce the amount of that assistance, national compulsory old-age insurance for the lower-income groups is necessary. Therein lies the justification for governmental action.

CHAPTER THREE

OLD-AGE ASSISTANCE

ALWAYS many persons have reached old age without adequate means of support; and there is every reason to suppose that this condition will continue for a long time. It is true that there is now an impressive array of public and private retirement systems. But many persons are not covered by those systems, either because they are not employees, or because they have not met the necessary qualifications. And many who do meet the minimum requirements qualify for benefits that are inadequate in amount to meet their basic minimum needs. For those persons, a system of assistance grants has been designed, although not all of the needy aged qualify for such assistance, and the grants are only too frequently inadequate to meet basic needs.

BEFORE THE SOCIAL SECURITY ACT

Among other things, the Social Security Act may be called the Magna Charta of the aged poor. For it marks the beginning of a comprehensive system of adequately financed and well-administered public assistance grants for them. But long before that Act, the cause of the aged poor had been championed by many, and some progress had been achieved.

Early State Movements. Realizing the inadequacy of public and private poorhouses and outdoor relief, socially-minded individuals began a movement to provide public pensions in this country. At least eight bills to pay pensions were introduced into the Federal Congress by the end of 1927, and many more in state legislatures. A series of state investigations into the conditions of the needy aged was initiated. The first of these were made by commissions appointed in Massachusetts in 1903 and 1907, although no immediate pension action resulted from the commissions' work. The reports

made by investigating bodies revealed conditions that were disquieting, and slowly agitation in favor of pensions developed.

In 1914, Arizona passed an initiative act abolishing almshouses and providing maximum pensions of \$15 per month, but it was so hastily and incompetently drafted that it was later declared unconstitutional because of its ambiguity. Alaska followed with a law in 1915 which provided pensions of \$12.50 monthly for needy pioneer residents 65 or over. No other law was enacted until 1923, when three more were added, largely as a result of the efforts of the Fraternal Order of Eagles. These laws were very similar to the present old-age assistance laws except that they were optional to the several counties.

The Fraternal Order of Eagles undertook to promote old-age pension laws. It drew up a bill providing pensions to bring income up to \$1 per day for persons 70 years or more having a minimum of 15 years of state residence, the law to be administered by a State Superintendent and local boards. Some success attended its efforts. But the acts were not mandatory on local government units, and the result was that most of them remained largely dead letters. The idea of local "voluntarism" almost wrecked the movement.

Mr. Abraham Epstein did more to foster the movement than any other man. Working at first with the Fraternal Order of Eagles, later for old-age pension commissions in Pennsylvania, and then through his American Association for Old-Age Security, organized in 1927, he made his influence felt throughout the country.

Slow progress was made in spreading the idea. A study published in 1925 by the United States Department of Labor revealing the high cost of poorhouses, and a book published in 1926 revealing the shocking conditions in those establishments appreciably stimulated the movement for pensions.¹ Before 1927, only five laws had been enacted, not counting the Arizona and Pennsylvania laws which were declared unconstitutional; five more were enacted before 1930. At the end of 1928, there were only slightly more than 1000 recipients of old-age pensions. The depression which began late in 1929 provided a stimulus to the enactment of state laws. By the beginning of 1935, before the Social Security Act, a total of 30 laws were in effect, 18 of them having been enacted in the Thirties.

¹ Estelle M. Stewart, *The Cost of American Almshouses*, Bulletin of the U.S. Bureau of Labor Statistics, No 386, and Harry C. Evans, *The American Poor Farm and Its Inmates*, Loyal Order of Moose, 1926.

Provisions of Early State Acts. Although they were a far cry from earlier methods of assisting the indigent aged, the laws were not liberal in terms of present standards, despite the fact that a substantial number of them were enacted or amended just prior to the passage of the Social Security Act and after considerable experience with the devastating effects of a major economic depression. The following description is of the major provisions of state laws before the Social Security Act was passed.

Conditions of eligibility were quite rigorous. In nearly one-half of the laws, only persons 70 years of age or over were eligible for assistance, and in most of the others the age was 65. All laws required state residence for 10 years or more except one which required only five years. In addition, county residence, varying from one to 15 years, was required, although in nine of the states county residence was not required for any specified period of time.

In addition to citizenship and residence requirements, most of the laws set property limits, usually \$2000 or \$3000. Frequently the laws provided that a lien could be taken on the property by the state before a pension would be granted, and the amounts paid in pensions could be recovered on the death of the pensioner. Generally there was also an annual income limit, usually \$300 or \$365. In some states, 5 percent of the value of property owned was counted as income. A few of the newer laws did not have either property or income qualifications, but empowered the agency administering the law to determine whether there was sufficient need to justify a pension.

There were many disqualifications. Persons in public institutions, or who had been sentenced for a crime, were generally disqualified, and frequently those whose spouse had deserted them and those who had failed without just cause to provide for wife and minor children were also disqualified. This was the old poor law concept that assistance should be given only to deserving and morally irreproachable persons. However, persons in private charitable or benevolent institutions were frequently eligible and their pensions were payable to the institutions. In those states, the institutions were subject to inspection and approval by the old-age assistance authority. It was also quite common to disqualify persons with relatives legally liable and able to support them. Anyone who had disposed of his property in order to become eligible to receive a pension was also generally disqualified.

The effectiveness of laws such as these depends largely on the ex-

tent of state participation in their administration and in their financing. Administration of the acts was weak in most of the states. In only 12 was there complete state supervision, usually by a State Board or Commission. In a few, the State Auditor was responsible. In about one-third, there was no state administration or supervision whatsoever, despite the fact that nearly all of these had mandatory laws, a trend which set in about 1929. Local administration was generally by county commissioners, in some instances serving as an old-age pension board or commission. In a few instances, state supervision consisted merely of receiving annual reports from local boards or county commissioners.

There was substantial financial participation on the part of some states. Nine states provided all of the funds used to pay pensions, but 13 contributed nothing. In the remainder of the states, the cost was divided between the state and local units, most frequently on an equal basis. The money usually came from the general fund, but receipts from special taxes were used in some instances.

Nearly all laws specified a maximum amount of pension that could be paid to any one individual. The amount was usually either \$25 or \$30 per month. Allowances for funeral expenses for pensioners were quite common.

It should be noted that not all of the laws functioned during the Great Depression. At the end of 1933, which was the depth of that depression, only 16 of the laws were functioning, and only 12 were functioning on a state-wide basis during 1934. Benefits were severely curtailed and pension rolls were practically closed in many states.

At the end of 1934, about one year before the Social Security Act became effective, there were approximately 236,000 out of an estimated 2,450,000 eligible aged persons on the old-age assistance rolls. and about \$32.3 million was paid out in benefits. The percentage of recipients to eligibles varied greatly, from less than 3 in Nevada to nearly 22 in Arizona. The average was 9.6. The average maximum monthly pension allowable was about \$25, but the average actually paid was somewhat less than \$15. Indeed, in 14 jurisdictions benefits averaged less than \$10 monthly. Here again there were marked differences as between states. Average monthly payments varied from 69 cents in North Dakota to \$26.08 in Massachusetts.

The long residence requirement found in the laws was one of the most serious limitations in the program. However, inability of state and local units to raise money was an even greater limitation. During

the depression, the ratio of recipients to eligibles was especially low in states having financial difficulties. There was clearly a crying need for Federal assistance, not only as a depression measure, but as a regular source of funds and to liberalize and to some extent improve administrative efficiency in state plans.

Early Attempts at Federal Legislation. What appears to be the very first attempt at Federal legislation was made late in 1909 by a former Secretary of Labor, Representative William B. Wilson. He introduced a bill to establish an "Old-Age Home Guard of the United States," to be composed of aged men and women. Eligible to "enlist" in the Guard were those men and women 65 or more who had property of less than \$1500 or an annual income of less than \$240. They were to be paid \$120 per year. This curious subterfuge won little support.

Another attempt was made in 1911 by the Socialist Congressman from Wisconsin, Victor L. Berger. He introduced a bill that would have granted a maximum weekly pension of \$4 to every person 60 years of age or over who had an income of less than \$10 a week, and who had been a resident of this country for at least 16 years. The bill made no progress whatsoever in the Congress. Subsequently many other bills were introduced, nearly all of them being of the straight pension type.

Late in 1927, a bill was introduced in the House of Representatives which was prepared by the American Association for Old-Age Security and sponsored by William L. Sirovich which proposed subsidizing states to the extent of one-third of the amounts paid out in pensions to citizens 70 years or over with incomes of less than \$1 a day and who had no children able to support them. That bill also received no serious consideration. But a bill introduced in 1932 was the subject of House and Senate hearings and was favorably reported by the House Committee on Labor and by the Senate Committee on Pensions, although it did not receive a rule which would have brought it to a vote. Adjournment came before any further action was taken.

The Great Depression which began in 1929 resulted in a tremendous volume of unemployment. Many older workers who had been self-supporting found themselves without jobs and dependent upon public relief. Many younger workers who had been supporting aged relatives also lost their jobs and were unable to continue their sup-

port, and many who did not lose their jobs suffered marked reductions in income and the burden of supporting their aged parents became insupportable. Many older workers did not lose their jobs, and considerable pressure developed to eliminate them from the labor market and thus make their jobs available to younger persons. The doctrine of economic maturity found widespread acceptance, and a part of that doctrine was that never again would there be jobs enough to go around.

The Townsend Crusade. A drastic change came about during the depression in public opinion on the subject of old-age assistance. That change is reflected in the general appeal made by the Townsend and similar old-age pension plans.

A truly national movement for old-age pensions developed which has come to be called the Townsend Crusade. Dr. Townsend was a retired physician who is said to have lost all of his savings in the 1929 crash and who then undertook to supervise the care of a group of indigent persons in California. As a result of the misery among old people which he saw all around him, he proposed a state old-age pension for California. Later, after President Roosevelt's social security message to Congress, Townsend and his associates espoused the idea, which was offered as a method of caring for the indigent aged but primarily as a method of recovering from the depression, of a Federal pension to persons 60 years of age or more who agreed to retire and to spend the money during the month in which it was received. The funds were to be secured by a 2 percent Federal transactions tax, the proceeds to be distributed up to a maximum of \$200 per month. It was estimated that the tax would yield \$24 billion annually.²

The plan made an intensely emotional appeal to a large number of Americans. Millions of persons, many of them under 60, were reported to have joined the movement and paid millions of dollars in weekly dues of 10 cents, although how many actually joined is not known. They banded themselves into thousands of Townsend Clubs, which were efficiently controlled from a National Headquarters and exercised considerable political influence, nationally and locally. A national weekly was also published. The organization appears to have been a profitable one for its owners and managers.

² *The Townsend Crusade*, Twentieth Century Fund, Inc., 1936.

Partly as a result of the Townsend Crusade, belief in old-age pensions became the most widely held economic and social doctrine in the United States.

In the House and Senate hearings on the Administration's Social Security Bill, in later hearings on the Townsend Plan itself, and in the press, the economic philosophy behind the movement, developed *ex post facto*, unfolded and gained wide acceptance among the country's masses, although not among its economists. Basically, the economic reasoning was simple, and fallacious. It was that huge sums of money given to and spent by old people would, in the process of being turned over, be multiplied tenfold monthly, thus creating enormous amounts of new purchasing power and stimulating business, employment, and prosperity. There was much discussion concerning the adequacy of the 2 percent transactions tax proposed to raise the necessary funds, and an unsuccessful attempt was made to get a satisfactory scientific study on that point.

A veritable flood of Townsend Plan letters and petitions criticizing the Administration's Social Security Bill and calling instead for \$200 monthly pensions made some Congressmen somewhat fearful of acting, and consequently delayed the actual passage of the Social Security Act. But the resulting agitation made the country pension conscious.

The Committee on Economic Security. President Roosevelt in a special message to Congress on June 8, 1934, announced that he was seeking a "sound means" to provide more security for the common man, especially in the matter of old age and unemployment, and that some actuarial studies were already in progress. Late in June he appointed the Committee on Economic Security, which consisted of the Secretaries of Labor, Agriculture, and Treasury, and also the Attorney General and Federal Emergency Relief Administrator. Professor Edwin E. Witte was made Executive Director. The purpose of the Committee was "to study the problems relating to economic security of individuals," and to make recommendations not later than December 1, 1934. An Advisory Council on Economic Security consisting of 23 representatives of workers, employers, and the public was provided, with which the Committee could and did advise, but this Council was not appointed until early in November. The President also appointed a Technical Board consisting of highly trained government specialists, with a staff of nongovernment specialists, to make the studies necessary to enable the Committee to arrive

at sound conclusions on policy. Seven advisory committees on special subjects were appointed: Medical, Public Health, Hospital, Dental, Public Employment and Public Assistance, Child Welfare, and Nursing. No special advisory committees for old age and unemployment were appointed, although these were the major subjects dealt with. A special committee of four of the country's leading actuaries was established to check actuarial and statistical methods and computations.

For six and one-half months the Committee on Economic Security and its various groups worked intensively, making studies, discussing proposals, deciding policies. The Committee had to decide in what fields it should act, although it was pretty well settled that old age and unemployment would be included and that health insurance would not be. The President seemed to be in doubt for a while as to whether the time was ripe for Federal old-age legislation, but no one else of importance seemed to be. The Committee had to decide also whether to recommend nationally administered and financed systems, 100 percent Federally supported state systems with money collected from special taxes, Federally subsidized state systems, or a tax offset system for unemployment compensation. Finally it had to decide how much the cost should be and how the money should be raised. The major provisions of each specific plan had to be devised and passed on. Advocates and opponents existed for every major proposal made, and there was necessarily much discussion and debate. It was really a colossal task which the Committee assumed and carried through with the help of its various committees. Information on which to base judgments was scanty and estimates, some of them of doubtful soundness, necessarily had to be relied upon. The question of constitutionality plagued the Committee and no doubt hampered its progress.

On January 15, 1935, the Committee on Economic Security reported to the President, who on the 17th transmitted the report to the Congress. In his message of transmittal, President Roosevelt recommended a Federal subsidy of 50 percent of the amounts spent by states for old-age assistance. He recommended that a compulsory contributory system of old-age insurance be established and that provision be made for a system of voluntary annuities. It was his opinion that the compulsory and voluntary annuities would in about thirty years make gratuitous grants to dependent aged persons largely unnecessary.

The time for a Federal plan of some kind had come. A broad foundation had been laid, the need was pressing, and extreme proposals were being popularized.

SOCIAL SECURITY ACT PROVISIONS

A Federal plan was developed. Under its provisions, grants-in-aid are made to states having old-age assistance laws approved by the Secretary of Health, Education, and Welfare.

Approval of State Acts. In order to be approved, a state program must (1) be state-wide in coverage, and if administered by local subdivisions made mandatory upon them; (2) provide that the state will participate financially in the program, but nothing is said about the extent of that participation; (3) be administered by a single state agency, or its local administration supervised by one; (4) afford opportunity for all to apply and furnish assistance with reasonable promptness to all eligible individuals; (5) provide a fair hearing before a state agency for those whose claims are denied or not acted upon with reasonable promptness; (6) provide personnel standards on a merit basis, although the Federal government exercises no authority over that personnel; (7) provide for the reports and information required by the Secretary to be filed; (8) provide for safeguarding confidential information concerning applicants and recipients, but the rolls may be opened to interested persons provided the information is not used for political or commercial purposes; (9) provide that a state authority will be responsible for establishing and maintaining standards for public and private institutions if assistance payments are made to individuals in them; and (10) provide that when determining the needs of an applicant the state will take into consideration all the income and resources the applicant possesses.

The Secretary of Health, Education, and Welfare may not approve any plan which imposes as a condition of eligibility: (1) an age requirement of more than 65 years; (2) any residence requirement of more than five out of the preceding nine years and one year immediately preceding the date of application; and (3) any citizenship requirement which excludes any citizen of the United States.

The Federal act does not define the concept of need or set up a minimum standard of living which will entitle an aged person to a grant. The Social Security bill as first introduced into the Congress did contain a provision to the effect that pensions granted plus

any private income must provide "a reasonable subsistence compatible with health and decency," and the translation of this concept into an objective standard was to be vested in the Federal agency administering that part of the act. Southern Senators and Representatives were bitterly opposed to that provision, because the living standard of their needy aged was generally quite low, and the provision was finally eliminated altogether.

Neither does the act establish standards to be used by the states in determining what constitutes need, although it does require the states to take into consideration any other resources that an aged applicant might have.

Some compulsion is applied in the matter of financial participation by the state, but only in the most general way, and the state is not required to contribute any specified amount or percentage.

Only a few basic minimum standards were laid down, and these were standards already in effect in all of the better laws. The basic philosophy of the Federal act is to allow the state as much latitude as possible and to assist it with money grants and some guidance. The Federal government, through the Social Security Administrator, will, however, decide what are necessary and proper administrative costs.

The Federal Grant. Under this program, the Federal government originally paid one-half of the amount granted by the state to any individual 65 years of age or over, but not to exceed \$15 to any one person. Later this was raised to \$20. In addition to this grant, the Federal government gave 5 percent of the amount of the subsidy, to be used for paying the cost of administering the state plan, although this could be used by the state for grants to individuals.

Beginning October 1, 1946, a different formula was used. The government paid as much as \$25 per month on account of any one recipient of old-age assistance. Furthermore, the proportion of the total amount spent by the state in old-age assistance grants which the Federal government paid was increased. The Federal government paid two-thirds of the total grants up to an average of \$15 per recipient, and one-half of the amount above the \$15 average, not counting sums in excess of \$45 per month for any one individual. These averages, it will be noted, were not of individual grants. A state paying one individual \$10 in old-age assistance and another individual \$20 received from the Federal government \$20, which is two-thirds of the total of \$30. Furthermore, the Federal govern-

ment paid one-half of the cost of administering the state acts, and the states could use this in whole or in part to increase their aid to old people. That put the Federal contribution for administration on the same basis as for aid to dependent children and aid to the blind.

In 1948 the contribution was made three-fourths of \$20 and half the remainder up to a maximum average of \$50, and in 1952 four-fifths of \$25 and half the remainder up to \$55.

PROVISIONS OF PRESENT STATE LAWS

The Social Security Act has brought about marked improvements in the provisions of state old-age assistance laws, although it has not brought any high degree of uniformity. A brief summary of the major provisions of state acts may now be given.⁸

The age provisions of the different state laws are now in conformity with the limit of 65 years specified in the Social Security Act, and Colorado will make payments to persons between 60 and 65 in certain cases, although it must do this altogether out of its own funds. In order to enable states to make the necessary adjustments, the Federal act allowed a transitional period during which states with higher-age limits could qualify for subsidies. Thus one of the worst features of the early laws has been eliminated.

Less than one-half of the states require citizenship as a condition of eligibility, and a few of these will waive the requirement for persons with from 15 to 30 years of residence.

Reasonableness has also been introduced into the residence requirements of state acts. Approximately one-third of the acts now have the maximum permitted by the Federal act, namely five in nine including the year immediately preceding application, although a few of these have more favorable alternatives applicable to some people. Approximately one-third of the laws require only one year of residence, and a few have no residence requirement at all. The Secretary of Health, Education, and Welfare has ruled that payments to recipients out of the state temporarily who intend to return may not be discontinued. Some states have gone beyond this ruling and will continue to make assistance payments to recipients moving out of the state until they become established in their new residences.

⁸ Changes in state acts are constantly being made, although the general outlines of the program are now clear.

Most of the movement to date appears to have been for the purpose of establishing residence near relatives.⁴

States are given complete power to define what constitutes basic need that will justify making a grant. Most of them define it as income inadequate or insufficient "to provide a reasonable subsistence compatible with decency and health." The same idea is sometimes expressed in such phrases as "deprived of the essentials of life," or "in need of relief and support." These states generally place a maximum on the size of the monthly pension that can be granted. One out of 10 states limits eligibility to persons with less than specified amounts of income. All of these generally allow extra amounts for medical care and funeral expenses.

Approximately 55 percent of the acts have no statutory limit on the maximum that can be granted monthly, and a few of these specify rather that the total income, including the pension, shall not be less than a specified amount per month. Of the acts that do have maximums, most specify at least as much as will yield the maximum Federal grant, and the others will no doubt raise their maximums. Colorado had a "jack-pot" provision in its law which required that at the end of each year the funds available for old-age assistance had to be distributed equally among the recipients. The provision was in effect repealed in 1947.

It is quite common to set property limits as a condition of eligibility, but there is no uniformity in the limits set. The maximum amounts, beyond which a person is ineligible, vary from \$300 in Utah and South Carolina to \$6000 in Michigan and New Mexico and \$8000 in North Dakota. In determining the disqualifying limit, some exempt the home the recipient is living in. The value is determined in some states to be the assessed valuation and in others the "net" value, generally less encumbrances. Some states also set personal property limits, which vary from \$150 to \$500 and generally include only cash, bank and postal deposits, although some include insurance as well. It is customary to require either that the property be assigned or transferred, or for the state to take a lien on the property and upon death sell it and recover the amounts granted.

Approximately one-third of the states have no specific limitation on the amount of income or property as a condition of eligibility.

⁴ *Social Security Bulletin*, March 1946, pp 39-42

Nearly all laws provide that the disposal of property in order to qualify will in itself make a person ineligible. There are no time limits on this disposal in half of the laws, and states having time limits set periods varying from two to 10 years.

There are three types of provisions relating to relatives who are legally responsible for the support of aged dependents and who are financially able to support them. One type provides for recovery from the responsible relatives by the state or local unit through the courts. A second type requires that assistance actually received from relatives be counted in determining eligibility or the amount of assistance to be granted. The third type disqualifies completely aged persons with relatives able to support them. The most stringent provisions are generally found in Northern states which have been paying pensions for many years. In the South and Southwest, where the pension movement had made relatively small headway until recently, and in many of the states with recent laws, less attention is paid to relatives, and in some states the ability of relatives is not even investigated. The trend is definitely away from requiring that relatives bear the burden, even where they are able to do so, although in 1947 a few states increased their requirements in this respect.

Administration of old-age assistance laws has been vastly improved. The extent of state administration is increasing. State supervision of local administration is being made effective by the development of state policy, rules, and regulations binding on local units and by the development of personnel standards. In two-thirds of the states, the administration of all forms of public assistance programs is centered in one single state agency.

OPERATION OF STATE ACTS

Operation of state old-age assistance acts may now be described, although the description will necessarily be in fairly general terms. Table 5 conveniently summarizes certain operational aspects of the system and at the same time indicates some trends.

Number of Recipients. In the month preceding the beginning of operations under the Social Security Act in 1936, the total number of recipients of old-age assistance payments amounted to only 431,000, and the average payment per recipient was only \$16.34. Only about \$155 million was spent during that year. Nearly one-

eighth of that money came from local sources and 45 percent came from the states. That represented a higher level than had been reached before, and was made possible by the enactment of many laws in the five years prior to the Social Security Act.

TABLE 5. Old-Age Assistance Recipients, Payments, and Source of Funds, by Year, 1940-1952 ⁵

Year	Number of Recipients (000's) Dec	Average Payment per Recipient Dec	Total Expenditures Full Year (000's)	Percentage of Funds from		
				Federal	State	Local
1940	2066	20 26	472,778	49.8	40 3	9.9
1941	2234	21 27	540,074	49 8	41 0	9.2
1942	2227	23 37	593,400	49 7	41 6	8 7
1943	2149	26 66	649,969	48 9	43 5	7.6
1944	2066	28 43	690,730	47 9	45 1	7.0
1945	2056	30 88	726,422	46.8	45 5	7.7
1946	2196	35 31	822,061	48 1	44 8	7.1
1947	2332	37 42	989,720	52.7	41 6	5.6
1948	2498	42 02	1,132,604	52 8	41 2	6.0
1949	2736	44 76	1,380,398	55 0	40 8	4.1
1950	2786	43 05	1,461,624	53 7	46 3	NA
1951	2701	44 54	1,433,989	53.2	40 5	6 3
1952	2635	48 82	1,468,040	53 1	40 4	6 5

Marked changes got under way immediately. Within 18 months, the number of needy persons receiving old-age assistance increased 250 percent, reaching 1,577,000 in December of 1937. The number of pensioners then continued to increase slowly, with only a few brief minor reversals, until June of 1942, when it reached a peak of 2,250,000. Intense war activity lured many of the aged into paying jobs, and induced many others to remain in employment. Furthermore, the need for assistance declined also as a result of income received by aged persons from family members of the armed forces and from other relatives enjoying full employment at high wages. The decline in the number on the rolls that set in after June of 1942 continued through August of 1945, when there were 2,033,135 recipients. Then largely because of declining employment opportunities resulting from cancellation of war contracts, the number on the rolls again began to increase. The total reached 2,809,537 in September

⁵ *Social Security Yearbook*, 1946, p 46; *Issues in Social Security*, pp. 338 ff, *Social Security Bulletins*.

1950, the largest number on the rolls to that date, but it has declined slowly since that time.

The upward trend is expected to continue, partly because the number of aged persons will increase, but mainly because it is believed that any slackening in the tempo of production will result in laying off relatively large numbers of the aged. In considering these figures, and future increases, it should be remembered that the number of persons 65 years and over increases now by about 200,000 annually. During the past five years, the number of persons 65 and over has increased by approximately 2 million, but the number on old-age assistance rolls has increased only slightly.

The figures given above generally understate the actual number of recipients. For about one-third of the states at one time made a single grant to married couples and reported that as a single recipient. The degree of understatement varies considerably, ranging in 1944-1945 from 2.1 percent in Missouri to 23.5 percent in Arkansas. Most of the states following this practice are in the South. The new formula for computing the Federal grant is modifying the practice, and part of the recent increase in reported numbers represents merely this change of practice.

It has been estimated that in June of 1948 an average of 213 persons per 1000 population 65 years and over were receiving old-age assistance. That is an overall figure, and there was considerable variation as between states.⁶ A fair idea of the extent of that variation may be had from the accompanying distribution of states according to recipients per 1000 population.

Recipients per 1000 Population 65 and Over	Number of States
Under 100	6
100 - 149	4
150 - 199	12
200 - 249	9
250 - 299	3
300 and over	15

Oklahoma, with 581 per 1000 population 65 and over, topped the list, followed closely by Texas with 487. Colorado, with 424 and

⁶ *Public Assistance*, A Report to the Senate Committee on Finance from the Advisory Council on Social Security, Senate Document No. 204, 80th Congress, 2nd Sess., p. 28.

Georgia with 418 were the only other states having more than 400. Lowest ranking states were the District of Columbia with 45 and Delaware with 56.

Variations as between states are accounted for in large part by differences in the incidence of poverty. In general, the poorer states had higher ratios than the more well-to-do. Differences in standards for determining need account for some of the variations, as do differences in conditions of eligibility. Industrialized states are wealthier than agricultural states, and in addition most workers in industrialized area become eligible for Old-Age and Survivors Insurance benefits. This last factor does not as yet account for much of the variation as between states.

Movement In and Out. There is a considerable movement of individuals into and out of recipient status. There are several important reasons why people seek old-age assistance grants. A study of cases opened in the last quarter of 1945 by the Social Security Board throws some light on the matter.⁷

Thirty-seven percent of the cases were opened because the applicants had lost their jobs. After V-J Day, jobs became less plentiful for the aged, partly because the need for labor declined and partly because many of the aged employed during the war were less efficient than others who could be hired. They were, in other words, marginal workers, as attested by the fact that 62 percent of the old-age openings because of loss of employment involved illness or disability. Only the direst need for labor made their employment at all possible and desirable. Loss of unemployment compensation benefits was found to exist in less than 1 percent of these openings, which means that the applicants were not employed in covered industry or had not accumulated enough credits to qualify for benefits.

Another major reason for openings was loss of service allotments, which inevitably followed reduction in the size of the armed forces. One out of eight openings was for this reason. The allotments were granted supposedly because these aged persons actually had been dependent upon the servicemen before they entered service. The fact that recourse to old-age assistance became necessary upon demobilization suggests that dependency really existed in a substantial number of the cases.

⁷ *Social Security Bulletin*, May 1946, pp. 32-37.

Depletion of savings and capital assets is next in importance as a cause of openings, and it accounted for 12 percent of the cases.

The remaining cases were opened for other reasons, most of which, 23 percent of the total, involved no change in financial status. A few had been in need for some time before applying but could not meet other necessary requirements such as age or residence, and some would have qualified but did not know of the program or had been reluctant to accept relief grants. Some openings resulted from shifts of blind persons receiving aid to the old-age assistance rolls when funds for the former program were running low.

These proportions are suggestive, but they are not typical. Normally fewer aged persons are employed and consequently openings resulting from loss of employment will be appreciably smaller. Fewer openings normally result from loss of allotments, this being an immediate postwar phenomenon. It is probable that openings resulting from depletion of savings are normally higher, because the period of time involved immediately followed the end of hostilities and some of the aged no doubt prolonged their financial independence with wartime savings.

Substantial numbers of cases are closed every year. During the three fiscal years 1940-1943, a total of 914,713 cases were closed. The closing rate, expressed in terms of the number of cases closed per 1000 open cases, increased during the war. It was 106 in the fiscal year 1940-1941, 115 in 1941-1942, 140 in 1942-1943, and 151 in 1943-1944.

As would be expected, death was the most common reason for closing cases, accounting for slightly more than one-half of them. Decreases in needs account for a substantial number, for about one-seventh. Other causes, such as movement out of the state, admission to institutions, refusal to comply with regulations, receipt of other forms of aid, and changes in agency policy, account for the remainder.

Closing figures of war years are not typical, for during that period relatively larger numbers went off the rolls into jobs, or received assistance from relatives. However, they do illustrate the movement off old-age assistance rolls.

Amounts Paid. Reference to Table 5 will show that total expenditures have steadily and appreciably increased. Assistance to the needy aged increased during the early years of the depression.

but it was not until late in 1934 that it reached substantial proportions.

In the second half of 1936, the effect of Federal subsidies made itself felt in a marked way. In January of 1936, \$7 million was paid; in July, \$13 million. Thereafter, the amount increased rapidly, and continued to do so even during the war years, despite a leveling off in the number of recipients. The total for 1952 was slightly less than \$1.5 billion, which was about 4.6 times as much as was paid in 1937 and slightly more than 2.6 times the amount paid in 1941, the last year before the war.

This increase in the total amount spent for old-age assistance has resulted partly from the increase in the number of persons receiving assistance. But the number on the rolls was only some 72 percent greater in 1952 than in 1937, whereas total payments were 360 percent greater. The difference is accounted for by higher average payments per recipient. Congress from time to time has increased the maximum average amount it would subsidize and also the proportion of that maximum it would pay. The effect on the size of the average payment and on the total amount expended has been marked. Continued increases can be expected in the number of recipients as the aged population increases, and in the size of the average monthly payment as prices and assistance standards go up.

Average payment per recipient has steadily increased since the Social Security Act became effective. In the month preceding the beginning of operations under the Federal Act, the average monthly payment per recipient was \$16.34. In Mississippi, the average was \$3.62 and in Arkansas it was \$5.90. By January of 1937, the average had increased 15 percent. Thereafter increases were smaller until 1943-1946, when they again became substantial. In December of 1951, the average monthly payment was \$44.54, and in no state was it below \$18. For Puerto Rico, where the Federal government grants only 50 percent of the first \$30 for any one individual plus one-half the cost of administration, the average was \$7.62, and in the Virgin Islands, which had the same matching formula, it was only slightly higher. A slight error exists in these figures, because they are averages of the number of checks written, and some states pay husband and wife with one check; however, the error runs through all the figures.

A different view of what has happened to the average size of

benefit payments is given in Table 6, showing the distribution of states according to average monthly payment. States with the lowest averages are in the South.

TABLE 6. Distribution of States According to Size of Average Monthly Payments, for Specified Periods

Size of Average Monthly Payment	Number of States					
	June 1936	Dec. 1941	Dec. 1943	Dec. 1945	Dec. 1946	Dec. 1952
Under \$10.00	5	5	1	0	0	1
\$10.00 - \$19.99	18	19	13	11	8	1
20.00 - 29.99	11	24	23	9	8	4
30.00 - 39.99	0	3	13	27	21	10
40.00 - 49.99	0	0	2	3	11	11
50.00 and over	0	0	0	1	3	25

There has been a marked increase in the number of states making the higher average monthly payments. In June of 1936, the average monthly payment did not equal \$30 in any state. By December of 1943, the number paying \$30 or more was 15, and in December of 1947 it was 39, nearly 77 percent of the total number. The national average for December 1952 was \$48.82. Twenty-eight states, 54 percent, including every Southern state except Louisiana and Oklahoma, paid less than the national average. There were slightly more than 1 million recipients in those states, or 46.6 percent of the total, and they received \$44.0 million, or 32.7 percent, of the total amount paid out in old-age assistance. The highest average monthly payment for December 1952 was \$84.22, made by Colorado. Six other states had averages exceeding \$60. The percentage of the total amount paid to recipients of old-age assistance in November of 1945 which went to persons receiving less than \$20 was 21.8; to persons receiving between \$20 and \$30 it was 50; and to persons receiving more than \$30 it was 28.1.

In general, the highly urbanized states pay appreciably more per capita than the highly rural states. In January of 1948, no highly urbanized state paid an average benefit of less than \$31.50, the highest being \$57.06 paid by California and \$54.96 by Massachusetts. The highly rural states in general paid appreciably less, and particularly those in the South. There are striking exceptions. Arizona, Idaho, and North Dakota all paid averages generally approaching those

of the highly urbanized states. The lowest average, \$15.83, was paid by Mississippi and the highest, \$84.62, by Colorado.

The two significant factors for both the number of recipients and size of average payment seem to be the extent of urbanization, with its attendant higher cost of living, and "pension philosophy." States in which the cost of living is high or in which there has been a strong pension movement pay relatively high benefits.

Recipients in institutions, on whose account the Federal government will now pay, receive the highest median monthly payments, no doubt because they need medical supervision and care. Recipients living alone receive the next highest median monthly payments, which is because they generally eat their meals out and room or house rent bulks relatively large in their budgets. Payments to married persons seem to reflect differences in methods of determining the size of payment rather than differences in need. Frequently in these cases one check is made out for two persons, or an old-age assistance check also takes care of dependents and other forms of assistance not available to dependents. Differences in medians for sexes also reflect differences in methods of making payments. It is common in some states to write one check for husband and wife and to make it payable to the husband. However, a surprisingly large number of women are given separate checks. The relationships here described held consistently for the fiscal years 1937-1940 inclusive, but do not hold in states which have relatively less adequate funds and those in which flat-grant-minus-income bases exist, such as Colorado, California, and Washington.⁸

Grants have not in general been considered adequate. A review of 14,000 cases by the Social Security Board in 1940-1942 showed that in 69 percent of the cases the grants failed to meet the needs of the recipients as those needs were determined by the agency making the grant, a much higher percentage than was found in grants to the blind, 60 percent, and grants-in-aid to dependent children, 47 percent. The major reason for this inadequacy is, of course, lack of funds, which in turn results from the poverty of many states and the limited Federal subsidy. Considerable pressure has consequently been exerted to induce Congress to increase the amount of its subsidy per person and to grant larger sums per person in the poor than in the relatively well-to-do states. But "adequacy" is a relative term

⁸ For a more detailed statement, see the *Social Security Bulletin*, for October 1941, pp 29 ff

and there is no reason to suppose that grants will ever be considered adequate, no matter how much they are increased.

Total expenditures per inhabitant for old-age assistance in 1944 were \$5.44 for the country as a whole. This compares with \$1.06 for aid to dependent children, 70 cents for general assistance, and 17 cents for aid to the blind.⁹ Variations between states were considerable, as the following distribution shows. For the fiscal year ending June 30, 1952, total expenditures per inhabitant for old-age assistance were \$9.52, compared with \$3.50 for dependent children and 37 cents for the blind.

Average per Capita Payment, 1951-1952	Number of States
Under \$ 2.00	4
\$ 2.00 - 3.99	6
4.00 - 5.99	2
6.00 - 7.99	10
8.00 - 9.99	14
10.00 - 14.99	10
15.00 - 19.99	3
20.00 and over	4

The lowest per capita payments were found in Puerto Rico, with \$1.02, and Virginia, with \$1.54, both of which have relatively small numbers on the pension rolls and low average monthly payments. They are poor, and perhaps not too much disposed to assist their aged. The highest per capita expenditure was \$32.96 by Colorado, which although not too wealthy has developed a powerful old-age pension movement. Three other states paid averages above \$20—Louisiana, \$24.82; Oklahoma, \$25.07; and Washington, \$21.06.

Source of Funds. The relative importance of different units of government as sources of funds is shown in Table 5. The percentage coming from the Federal government has consistently been very nearly 50, and because of the change in formulas made in 1946 and 1952 is likely to continue well above 50 percent. This may be taken to indicate that the Federal contribution is a major limiting factor in total expenditures for old-age assistance, and that is no doubt so. But it also may indicate that to some extent the states are unwilling,

⁹ *Ibid.*, June 1945 and April 1953.

as well as financially unable in part, to assume larger burdens. The same reluctance to spend appears also in the field of public education in the same states.

Contributions made by the state units have come to assume quite substantial proportions, considering the woefully inadequate part played by state money before the Social Security law was enacted. State contributions have been pretty close to 40 percent of the total, and the range of variation as between states has not been significantly great.

Local units now contribute relatively little, and the proportion is steadily decreasing, although the total amounts involved are substantial. Local contributions were only 5.6 percent of the total in 1947. In approximately 60 percent of the states, local units made no contributions at all in that year. In those states where local units contributed in 1946, the range was from almost nothing to 24.1 percent in Kansas. In 10 states, as much as 20 percent came from local governmental units. The percentage is now increasing slightly.

The Federal government appropriates money for public assistance from the general fund and has no source of revenue specifically earmarked for that purpose. Before the Social Security Act was passed, local governmental units frequently had fixed mill levies on real property to finance assistance programs, and states usually appropriated from general revenues. The depression resulted in special levies for relief purposes, these being usually additions to existing levies such as sales taxes, the additional sums received being diverted to welfare purposes.

Soon after the Social Security Act was passed, the trend was for states to levy special taxes or to earmark revenues from certain taxes. Many of the states used money they collected from various types of sales or use taxes. More recently the trend has been to secure the state's share wholly or partly from general revenue funds. Approximately 70 percent of the states now finance their old-age assistance programs from general revenues only. Income and sales taxes supply much of the money that goes into the general revenue funds.

The earmarking of tax revenues for assistance purposes appears to many to have the advantage of providing a definite source of income. But the practice has certain disadvantages. Assistance revenues may fluctuate violently and thus seriously affect the level of operations. An uneven development of governmental functions may develop—

old-age pensions at the expense of general assistance and all assistance at the expense of schools. Earmarking interferes with proper budgetary planning and the control of state and local expenditures.

SOME TRENDS

The Means Test. Basically, the old-age assistance program was conceived as a program whereby government would supplement existing income to the end that a reasonable minimum level of living would be available to the dependent aged. A "means" test would therefore appear to be an essential element in the program. But there is a tendency for states to establish generalized methods of determining the size of old-age pensions rather than basing them on individual needs. In a few states, assistance payments approach the statutory or administrative maximums. Administrative difficulties involved in determining needs account in part for this trend. But there also appears to be some desire to eliminate the practice of having state and local officials pry into the private affairs of needy individuals, or of those who claim to be needy. The feeling seems to be growing that all needy aged persons have equal rights to public funds. Some states allow for exceptions to their statutory or administrative maximum amounts, and this of course is contrary to the tendency just described of paying uniform amounts irrespective of the degree of need.

Size of Grant. There is a definite and strong trend towards liberalizing the maximum amount that can be paid in assistance. To some extent this is accounted for by the marked increase that has taken place in the cost of living, but in part it reflects an attempt to improve the lot of the needy aged. The political factor cannot be ignored. Aged persons in some states exert considerable political influence. In part, the liberalization is the result of another trend, the trend toward shifting the brunt of the burden from local to state and Federal governments.

Responsibility of Relatives. Careful investigation is required to determine the amount of assistance needed to supplement existing resources. But less emphasis is being given to the ability of relatives to support aged applicants. The range of relatives that can be considered responsible is being reduced. A few states specify that relatives with low incomes or who have heavy family obligations

should not be considered as sources of aid, and in most states these are not expected to contribute. And even when it is found that relatives could but do not contribute, the tendency is to pay the assistance anyway, and not to bring legal action against them to compel support.

This is no doubt what the Massachusetts Commission on Old-Age Pensions had in mind when years ago it spoke of the danger of family disintegration. What appears to be happening is that the concept of the family has definitely been narrowed to eliminate the more distant relatives and is being further narrowed to eliminate children who themselves have family responsibilities. It is worth noting that a family consisting say of father, mother and three children can itself disintegrate, or be seriously demoralized, if required to support grandparents, uncles, and cousins. Whatever the moral philosopher may think about it, the American people like the idea of shifting from relatives to taxpayers the burden of supporting the indigent aged.

This trend has gone even further. Some states exempt a part of the applicant's income when determining his needs. Pushed to its logical conclusion, this move would eliminate entirely the idea of "assistance" and would result in flat pensions regardless of need. There are many who would go that far. Property limitations restricting eligibility are also being liberalized in some states where they exist.

Assistance to Those Institutionalized. When the old-age pension movement was getting under way in this country, there was much discussion about the high cost of maintaining the poor in county homes and of the deplorable conditions under which the inmates lived. Many firmly hoped that pensions would replace poorhouses, and Arizona in her first act provided that all almshouses should be abolished and the buildings and grounds sold. The Social Security Act at first provided that no Federal money would be used to pay pensions to persons in public institutions. That policy has been changed and payments to persons in public medical institutions, other than those suffering from mental disease or tuberculosis, will now be subsidized. Furthermore, now the Federal government will also contribute toward the cost of medical and hospital care even though the payments are made directly to practitioners and institutions, but only within the same average maximum limits. There must be a state authority responsibility for establishing and maintaining standards for those institutions.

ASSISTANCE AND INSURANCE

There are certain similarities in our Federal Old-Age and Survivors Insurance system and state old-age assistance systems. In both the eligibility age is 65, for both men and women. In both an individual who is denied insurance or assistance is entitled to a hearing. Both assure the individual privacy in his personal affairs. Both pay in cash and neither restricts the use that can be made of the money received. Both are intended to supplement other income and the sums paid tend to fall within the same fixed limits. And the Federal government is involved in both, although in different ways.¹⁰

Some of the differences between the two, although not perhaps fundamental, are rather significant. Most old-age insurance primary beneficiaries are men, whereas the sex distribution in old-age assistance conforms to that of the general aged population. Negroes are overrepresented on the assistance rolls and underrepresented on the insurance rolls. Old-age insurance families with primary beneficiaries are larger than families with old-age assistance recipients. The average primary beneficiary family has a substantially higher income than the average assistance family, which is not due to the insurance benefit but to other sources of income. A larger number of public assistance families are entirely dependent on assistance payments than is the case of insurance families.¹¹

Really fundamental differences exist between the two systems. The insurance system is compulsory and nation-wide in coverage, it is contributory, benefits are based on earnings, and it is administered by the Federal government. The assistance system is voluntary, gratuitous, benefits are based on needs, and it is administered by the states. The insurance system because of its infancy, now serves fewer beneficiaries than does the assistance system, but in the course of a short generation will, or should, serve considerably more.

¹⁰ Merrill G. Murray and Elinor Pancost, "Trends in Old-Age Assistance," *Social Security Bulletin*, September 1945, pp. 12-15.

¹¹ *Social Security Bulletin*, December 1944, pp. 9-14.

CHAPTER FOUR

THE FEDERAL OLD-AGE AND SURVIVORS INSURANCE SYSTEM: PROVISIONS

THE Federal Old-Age and Survivors Insurance system is designed to provide cash benefits to those persons who have met all of the requirements laid down in the law. Several general characteristics of the system should be noted before a detailed description is given.

Geographically, the system is nation-wide in scope, covering all the states, the District of Columbia, Alaska, Hawaii, Puerto Rico, and the Virgin Islands. It is administered exclusively by the Federal government, except that state agencies determine whether an insured is totally and permanently disabled. It is a compulsory system, except that states and certain nonprofit organizations may now voluntarily assume coverage for their employees, and under specified conditions may later withdraw voluntarily from coverage. To a limited extent, business organizations and private individuals are permitted to elect coverage. All classes of income receivers are included. It is not just "workingmen's" insurance. Those who qualify for benefits are eligible to them as a matter of right, irrespective of whether they need the money. Employers and employees contribute equal amounts to provide benefits to employees and their dependents and survivors, and employers and self-employed persons without employees contribute to provide benefits to themselves and to their dependents and survivors. The Federal government pays no part of the benefits or of the administrative costs, and it is not pledged to meet any deficit that may develop. The system is designed to be wholly self-supporting.

Thus it is a system of insurance and not of relief, although lower-income groups are definitely favored at the expense of higher-income groups, and older persons qualifying for benefits in the beginning years and after the "new starts" in 1950 and 1954 get a great deal

more for their money than will those who qualify after the system has become stabilized. Insured women will generally get less from the system than they put in, especially the higher-paid ones, because for the most part they do not have many dependents and survivors.

MAJOR PROVISIONS OF THE SYSTEM

The system has become exceedingly complicated and is likely to become even more so. A summary view of its structure can be given by describing the major provisions concerning coverage, benefits, taxes, and administration.

Coverage. The original Act, passed in 1935, established a pure and simple retirement plan with only one benefit. Its inadequacy being quickly realized, a drastic revision in 1939 added a fairly comprehensive system of benefits for dependents and survivors of employees. Workers in some employments, as in agriculture and in domestic and public service, were excluded. The scope of the system was broadened still more by amendments in 1950 and 1954 which included self-employed persons and most of the employments previously excluded.

Persons. Employees covered by the Act consist of corporation officials, "any individual who under the usual common law rules applicable in determining the employer-employee relationship, has the status of an employee," and persons working for pay for someone else (1) as an agent-driver or commission-driver distributing meat, vegetable, fruit, and bakery products, laundry or dry-cleaning services, and beverages other than milk; (2) as a full-time life insurance salesman; (3) as a "home worker" on material goods, if the worker is paid at least \$50 in any calendar quarter; and (4) as a full-time traveling or city salesman soliciting orders for merchandise for resale or supplies for their own use from business establishments. However, solicitors who have a substantial investment in the facilities used, except for transportation, or whose services are not part of a continuing relationship with their principal, are not considered to be employees. There is no numerical exception limiting coverage such as is found in many unemployment insurance and workmen's compensation laws.

Employers and the self-employed are persons engaged on their own account in trade or business and they are now included provided their net earnings as computed for this purpose—technically

their "adjusted gross income"—for the year amount to at least \$400. But public officials, persons under 18 who deliver newspaper or shopping news, and employee representatives, i.e., union officials, are specifically excluded from coverage, as are members of religious orders who take a vow of poverty. Workers covered by the railroad retirement system are also excluded. The following self-employed professional workers are also specifically excluded: physicians, lawyers, dentists, osteopaths, veterinarians, chiropractors, naturopaths, and optometrists. Farmers and farm operators were included by the amendments of 1954.

Employments. Until 1951, service in certain employments was excluded from coverage. The most important of these were agricultural labor, domestic or household service, public service whether governmental or proprietary, and service for certain nonprofit institutions for charitable, religious, scientific, literary, or educational purposes. This list of excluded employments has been appreciably reduced.

In general, the employments now covered include all services for pay or gain, but there are still some exceptions. One is service performed for the Federal government or its instrumentalities if another retirement system is applicable or if the instrumentalities are tax-exempt. Railroad employment, which is covered by a separate act, is also excluded, although it may under certain conditions be included. Service for foreign governments and for educational institutions by students who are also regularly attending classes is not included. The services performed for a son, daughter, or spouse and by children under 21 for their parents in any employment are specifically excluded.

Until 1951, agriculture was completely excluded from coverage. Now the service of workers on farms who are paid at least \$100 in cash during a calendar year from a single employer is covered. It is no longer necessary that the worker be a "regular" employee "continuously" employed for any specified period of time. A farm household employee's services are covered under exactly the same condition. Service performed in connection with the production or harvesting of crude gum from a living tree, gum spirits of turpentine, and gum rosin, or with the production or ginning of cotton is entirely excluded.

Domestic or household service was also excluded until 1951. Now such service performed for local college clubs, fraternities, and so-

riorities by students regularly enrolled in and attending classes is still exempt. All other household service is covered for any calendar quarter in which the employee is paid at least \$50 in cash by a single employer. Until the 1954 amendments, the household worker must also have been employed on at least 24 different days in the quarter. Domestic service on farms operated for profit is treated in the same way as farm labor.

Service for state and local governments, whether governmental or proprietary in character, may now be included. This is done by means of a voluntary agreement entered into by the state and the Secretary of Health, Education, and Welfare. No agreement will be made directly with a local political subdivision, such as a city or county. The agreement may apply to all officials and employees or to "coverage groups" performing either governmental or proprietary functions. A state may, for example, make an agreement that covers the employees of its state schools, the employees of a local school system, the employees of a city water plant, or any other distinctive group of employees. All of the services performed by employees in such groups must be included, except that purely emergency and part-time services may be excluded. The services of elected officials and services rendered for fees may also be excluded if the state so desires. The state may, if it desires, include all of its own agricultural labor and student help. But no agreement may include unemployment relief work, service by patients or inmates of public institutions, or service otherwise excluded by the Act, except agricultural labor and student help. The agreement may be modified from time to time to include additional coverage groups or services.

When this extension of coverage was first made possible, in 1950, it was provided that no agreement could be made to include services covered by a state or local retirement system at the time the agreement became effective. It was, of course, possible to terminate a system, achieve coverage, and immediately thereafter reenact the same system or a modification of it. This was done in some cases. But fear that legislatures would not reestablish a system, or a reasonable modification of it, led to much pressure against seeking coverage.

This strange provision, which appears to have been inserted as a result of influence exerted by persons opposed to extending the Act to public employees, was changed in 1954 to allow inclusion of all except firemen, policemen, unemployed persons on work relief,

working patients in hospitals, homes, or other public institutions, and those employed in "covered" transportation. However, where there is a retirement system already in effect, there must be a referendum by secret ballot, held after at least 90 days' notice, conducted under the supervision of the Governor or of some person or agency designated by him, in which a majority of the eligible employees vote in favor of being included. Members of the retirement system are considered to constitute an appropriate coverage group, and if the vote is favorable all of the services performed by members of the group are included.

The state is responsible for paying the taxes levied on the employer and the employee, as is true of private employers. Should the state fail to pay, or pay less than the amounts due, the amounts due plus interest at 6 percent may be deducted by the Federal government from its grants-in-aid to the state for other social security programs such as old-age assistance and aid to the blind. The deducted amounts will then be appropriated for the Federal Old-Age and Survivors Trust Fund, and will be considered as payment of the taxes levied.

An agreement extending coverage to state and local employees may be terminated by the state in its entirety or for any coverage group or groups, after giving written notice two years in advance of the intended termination date. But this can be done only after the agreement has been in effect for at least five years prior to receipt of the notice. The coverage voluntarily assumed thus becomes compulsory for a minimum of seven years. After reasonable notice and opportunity for hearing, the Administrator may terminate the agreement in its entirety or for one or more coverage groups if he finds that the state has failed or is no longer legally able to comply substantially with the provisions of the agreement. This must be done not later than two years after proper notice has been given to the state. Once an agreement has been terminated wholly or in part, no new agreement may be made to replace or to modify the agreement, or that portion of it, that has been terminated. It should be added that the inclusion, in the system, of some publicly owned local transportation systems acquired from private owners since 1936 is now compulsory.

Service in certain tax-exempt nonprofit religious, charitable, educational, and other similar organizations, which was not covered by the Act before 1951, may now be brought within the system volun-

tarily by the organizations. The procedure differs from that for states. The nonprofit organization must poll its employees on whether they desire to be included. If at least two-thirds of them desire coverage, each individual concurring in the employer's request to be covered signs a list so indicating. The organization then files a certificate certifying that it desires to be included in the system, together with the list of concurring employees. The certificate becomes effective the day following the close of the quarter in which it is filed. Coverage is then extended to the employees who signed the list. The list may be amended by filing supplemental lists, giving the names of additional employees who wish to be covered, within two years after the quarter in which the certificate becomes effective. All persons who become employees after the calendar quarter in which the certificate becomes effective are automatically and compulsorily included. Thus old employees who do not sign the list are not covered. The organization may terminate coverage, without reference to the desires of its employees, by giving two years' advance notice in writing. But the notice of termination can be given only after the certificate has been in effect for at least eight years. This means that coverage, once assumed, may not be relinquished for ten years. An organization terminating coverage may not file a new certificate. The coverage may be terminated at any time by the Federal government if requirements are not substantially complied with.

Duly ordained, commissioned, or licensed ministers and Christian Science practitioners may elect, on an individual basis, to be covered by the Act. They are considered as self-employed persons.

Insurance Status. The benefits provided by the Federal Old-Age and Survivors Insurance system are payable only if the individual upon whose wages or self-employment income they are based is properly insured at the time of retirement or of death. It is necessary, but not at all difficult, to acquire the proper insurance status. A person can be insured in either or both of two different ways, and for some benefits both are required.

Fully Insured. A person is "fully insured" if he has acquired (1) an absolute minimum of six "quarters of coverage" and (2) one quarter of coverage for every two quarters elapsing after 1950 or after the quarter in which he reaches age 21, whichever is later, and up to but excluding the quarter in which he reaches age 65 or dies, whichever occurs first, or (3) a total of at least 40 quarters of cover-

age. Reference to death is included because survivor benefits are payable on the death of a fully insured person. If the total of quarters elapsed is an odd number, it is reduced by one. Anyone having 40 quarters of coverage, whenever acquired, is "permanently" fully insured, irrespective of how many quarters have elapsed. And so is anyone who has less than 40 quarters but who has one quarter for every two elapsing since 1950 and before age 65. Thus many older persons will be permanently fully insured with far less than 40 quarters of coverage. Beginning July 1, 1955, in determining whether the one-in-two requirement has been fulfilled, any quarter during a "period of disability" that is not also a quarter of coverage is not counted as time elapsed. The disability feature will be explained in some detail below. Briefly, it means that the insurance status is "frozen" during a period of total and permanent disability.

Special provision is made for persons newly covered by the amendments of 1954. Such persons who die or attain age 65 before July 1, 1958, are deemed fully insured if all the quarters elapsing after 1954 and up to but not including the quarter of death or age 65 are quarters of coverage and if there are at least six of them. Thus newly covered older persons who will be unable to fulfill the requirement of one quarter of coverage for each two quarters elapsing after 1950 and before death or retirement are protected. After the third quarter of 1958, the regular requirements apply to all.

A quarter of coverage is a three-month period, ending March 31, June 30, September 30, or December 31, in which the person is paid at least \$50 in covered wages or is credited with at least \$100 in covered self-employment income. Anyone paid or credited with a total of \$4200 in a year, after 1954, in wages or self-employment income or in both combined, acquires four quarters of coverage for that year, excepting the quarters after the one in which he dies, and excepting also any quarter any part of which is in a "period of disability" except possibly the initial and last quarters of that period. But no quarter will be counted for the purpose of determining insurance status prior to its beginning. The same is true for those receiving at least \$3600 for the years 1951-1954. Those who received at least \$3000 in any years before 1951 are credited with all quarters following their initial quarter of coverage in that year. Quarters of coverage need not be acquired in any particular sequence. They may be acquired before age 21 and after age 65, as well as during the normal working years. Any quarter acquired at any time since 1936

may be counted in determining whether a person is fully insured.

Special provision is made for determining quarters of coverage for agricultural workers after 1954. If paid at least \$100 but less than \$200 for agricultural labor, they are credited with the last quarter in that year. The last two quarters are credited if the wages paid are at least \$200 but less than \$300, and the last three if wages are at least \$300 but less than \$400. If paid \$400, all quarters are credited. These quarters will be credited only if they are not also creditable for wages paid in other occupations or for self-employment income.

Assume, for example, that a worker was 60 years old on December 31, 1950. He needs an absolute minimum of six quarters of coverage, and, under the one-in-two rule, that number will make him fully insured until the end of the first quarter in 1954. He attains age 65 on December 31, 1955. Since the quarter in which he becomes 65 is not counted, a total of 19 quarters will have elapsed. This is an odd number and therefore it is reduced to 18. He will, at age 65 and thereafter, need nine quarters of coverage to qualify as fully insured. Once this worker has acquired nine quarters of coverage, whether before, during, or after 1950, he will be "permanently" fully insured, for he will have met the one-in-two requirement.

A young man who attains age 21 after 1950, say on November 22, 1954, will need 40 quarters of coverage to be fully insured at age 65. Until he has acquired 40 quarters of coverage, he will be held to the one-in-two rule. Should he die in January 1965, he would be fully insured if he had accumulated a minimum of 20 quarters of coverage, i.e., one for every two elapsing after the quarter in which he attained age 21 and before the quarter in which he died.

Currently Insured. Some benefits are payable even though fully insured status has not been achieved, provided the covered individual was "currently insured." To be currently insured, a person must have acquired at least six quarters of coverage during the 13-quarter period ending with the quarter in which he dies or becomes entitled to a primary benefit. Coverage acquired prior to this 13-quarter period may not be counted in fulfilling the requirement. Here also quarters in a period of disability which are not quarters of coverage are not counted as time elapsed, and therefore the actual number of calendar quarters in the period may be more than 13.

Assume that a young man who is 21 years of age on November 22, 1960, enters covered employment for the first time on June 1, 1967, that he works steadily until he dies in January 1972, and that he is

paid at least \$50 during each month of covered employment. What is his insurance status? A total of 44 quarters elapse between age 21 and death. He has 20 quarters of coverage. That is less than 40 and it does not meet the one-in-two requirement. Therefore he is not fully insured. But he does have at least six quarters of coverage in the 13-quarter period ending March 31, 1972, the quarter in which he died. Therefore he is currently insured, and his survivors will be entitled to benefits. Protection for survivors is thus much more easily obtained than is qualification for a retirement benefit.

The Primary Benefit. Although it began as a simple retirement benefit plan, the Old-Age and Survivors Insurance system now provides monthly benefits to dependents and survivors as well, and there is also a small lump-sum benefit payable on the insured's death. The key to the entire structure is the old-age insurance benefit, commonly called the primary benefit. To be entitled to this benefit, a person must (1) be fully insured, (2) be at least 65 years of age (there is no distinction between men and women), and (3) have filed an application for the benefit.

Two different methods are used to compute the retirement benefit and the benefit amount upon which payments are made to survivors in case of death before retirement. The standard method is the one that in due time will be used in all cases. A supplementary method is used in cases where counting credits acquired under the Act prior to the 1954 amendments enables the recipient to receive a larger benefit than is yielded by using the standard method.

The method that will generally be used to determine the benefit for those who first qualify for benefits after August, 1954, or who die after that date, and who have acquired at least six quarters of coverage since 1950 is as follows. First the insured person's "average monthly wage" is computed. All covered wages and self-employment income received after the insured's "starting" date and before his "closing" date, not counting amounts above \$4200 in any one year, are added and the total is divided by the number of months elapsing between those two dates. For the years 1951-1954, the maximum was \$3600, and for the years before that it was \$3000.

The starting date is December 31, 1950, or for one who attains age 21 after that date it may be the last day of the year in which he attains age 21, if using the latter date gives him a higher average monthly wage. But if a person who attains age 21 after 1950 uses December 31, 1950, as a starting date, no month in any year preced-

ing the year he attains age 22 in which he acquired less than two quarters of coverage will be counted as time elapsed. Thus young persons entering the labor force after 1950, whose incomes are likely to be low, are not penalized by having that time counted against them. For those who were covered by the Act before the 1950 amendments the starting date may also be December 31, 1950, if they have acquired at least six quarters of coverage after 1950 and if that starting date gives them a higher average monthly wage. Otherwise their starting date is December 31, 1936, and their benefit is determined in a different manner.

There are alternative closing dates. One is the first day of the year in which an insured person dies or becomes entitled to an old-age insurance benefits, whichever occurs first. It will be recalled that to be so entitled a person must be fully insured, have attained age 65, and have filed an application for the benefit. The other closing date is the first day of the year in which the person is both fully insured and attains age 65. In this case he would not have filed an application at the time and would not therefore be "entitled" to the benefit. The date yielding the higher primary insurance amount is used. However, if adequate evidence of earnings is available at the time of computation, the closing date will be the first day of the year following the year of death, entitlement, or acquisition of fully insured status and retirement age, if using that date will result in a higher primary benefit. If adequate evidence is not available, the benefit will be recomputed when the evidence becomes available, if the benefit will be increased as a result.

Special provision is made for persons dying or becoming entitled to benefits in 1956. In their cases, the starting date may be December 31, 1954, and the closing date July 1, 1956, provided at least six quarters elapsing after 1954 and before death or entitlement, whichever occurs first, are quarters of coverage. Wages and self-employment income in excess of \$2100 received after December 31, 1955, are not counted when this procedure is used. These dates are used only if they yield a higher benefit amount than the person would otherwise have received. Persons first covered by the 1954 amendments may thus qualify for the maximum benefit allowed, if their covered wages or self-employment income amount to \$350 monthly during the months between the starting and closing dates.

Under certain conditions it is possible to exclude some of the time elapsed and income received between starting and closing dates.

This is the "drop-out" feature introduced by the 1954 amendments. As many as four years in which there was no covered income or in which covered income was the lowest may be excluded in computing the average monthly wage if the insured person acquired at least six quarters of coverage after June, 1953, or if he first becomes entitled to benefits after August, 1954. Those years will also be dropped out in computing survivor benefits where the insured person dies after August, 1954, and is not at the time of death a primary beneficiary. For persons having at least 20 quarters of coverage a total of five years may be dropped out. Thus persons newly covered by the amendments of 1954 will not have the years 1951-1954 counted against them. Others, who have years of low covered income, will also benefit. Under certain conditions, periods of total disability may also be excluded, effective July 1, 1955. But in every case, an absolute minimum of 18 elapsed months must be counted.

The maximum average monthly wage possible is \$350, and it can be attained only by persons who have covered income of at least \$4200 for each included year. The average monthly wage of an insured person whose total credited and counted covered income is \$12,500, whose starting date is December 31, 1950, and whose closing date is January 1, 1956, is \$12,500 divided by 60, or \$208.33.

When the average monthly wage has been computed, the primary benefit amount is easily determined by taking 55 percent of the first \$110 plus 20 percent of the next \$240. Thus the absolute maximum, yielded by an average monthly wage of \$350, is \$108.50. This maximum will not be paid until after June 30, 1956, because not until then will anyone have been credited with the maximum taxable income for the required minimum number of quarters. The previous maximum was \$85. When the primary benefit or any other monthly benefit as computed is not a multiple of ten cents it is "rounded" by being raised arbitrarily to the next higher multiple of ten cents.

The formula for computing the primary benefit is weighted in favor of the low-income groups. As the law stands under the 1954 amendments, a man with an average monthly wage of \$100 would receive \$55 a month, whereas a man with a wage of \$300 would receive \$98.50, a difference of \$43.50. In this comparison, three times as much in taxes brings slightly less than 1.8 times as much in benefits. For one with an average monthly wage of \$30 or less, the difference is even greater, since he would receive \$30. Thus it is possible for some people to receive a monthly benefit larger than their aver-

age monthly wage. This heavy weighting in favor of the low-income groups is one of the elements that go to make the plan "social," as distinguished from "commercial" insurance. The same principle is applied in a different way in our income-tax law.

The primary benefit is payable beginning with the month in which the beneficiary becomes entitled to it and ending with the month before the month in which he dies. Although a person must file an application in order to be entitled, benefits are paid retroactively to the month in which a fully insured person attained age 65 if the application is filed not more than 12 months after that month. Thereafter each month's delay in filing means the loss of one monthly benefit. An application for a benefit filed within the three-month period preceding the month in which the benefit is first payable is acceptable.

Approximately 6.5 million persons were already on the benefit roll when the new formula established by the 1954 amendments became effective. The benefits of all those persons were raised, beginning September, 1954. Essentially that was done by applying the 1954 formula to the average monthly wage on which the old benefits were based. But where the increase in benefits as so computed was less than \$5, the old benefit was arbitrarily raised by \$5. There is a "conversion table" in the Act which facilitated the determination of the benefit increases. For example: if the benefit under the old formula was \$60.80, the new benefit became \$66.30. The largest increase went to primary beneficiaries receiving \$85, the maximum benefit before the amendments of 1954. Their benefit was raised to \$98.50, an increase of \$13.50.

The conversion table is used to arrive at individual benefits first payable after August, 1954, in cases where no years can be dropped out in computing the average monthly wage, as when survivors qualify for benefits based on earnings of insured workers who died before September 1, 1954. It is used also to determine primary benefits for fully insured persons who attained age 65 before September 1, 1954, but who do not apply for benefits until that date or later. Where an average monthly wage is less than \$130, the 1954 formula may not yield as much as \$5 more than the 1952 formula would have yielded. The conversion table is used to assure that increase. In these cases the 1952 formula—55 percent of the first \$100 and 15 percent of the next \$200—is used to compute the benefit to be converted.

The system began January 1, 1937, and some workers have been

covered by it for many years. Insured workers who were 22 years old before 1951 and who acquired at least six quarters of coverage after 1950 may have their primary insurance amount based on earnings since 1936 rather than 1950, if that will yield them a higher benefit. The 1939 formula would then be applied—40 percent of the first \$50, 10 percent of the next \$200, and one percent of the total of these two sums for each year before 1951 in which they were paid at least \$200 in covered wages. That benefit amount would then be raised by using the conversion table. If an insured person's primary benefit computed on earnings since 1936 amounted to \$44, for example, it would be increased to \$86.70. His benefit computed on earnings since 1950, using the 1952 formula, would have to be \$76.10 to yield the same amount.

The problem involved in making transitional adjustments when coverage and benefits are changed are complicated. Only an expert can find his way through the maze of legal terminology that must be used, as for example in determining benefits where neither the standard formula nor the conversion table is applicable. But these problems decrease in relative importance as time passes and the standard benefit formula becomes applicable to more and more of the insured and to their survivors. Most of those first awarded benefits after August, 1954, now have the amounts computed under the standard formula—using earnings after 1950, dropping out four or five years of low income, not counting time of permanent total disability beginning July 1, 1955, 55 percent of the first \$110 and 20 percent of the remainder. That will be true for practically all beneficiaries in a few years, unless Congress again makes drastic changes in the system.

Provision for Disability. Considerable pressure to establish a system of permanent total disability benefits has been exerted for many years. In 1952, Congress adopted an amendment to the Old-Age and Survivors Insurance law that would have "frozen" the status of persons permanently totally disabled, but it did so only to break a deadlock and with no serious intention of making it effective at that time. The amendment was to become effective only if reenacted before July 1, 1953. Congress did not reenact that amendment in time to make it effective, but in 1954 it did provide for "freezing" the status of permanently totally disabled persons, effective July 1, 1955. Only benefits payable after June 30, 1955, can reflect the application of this provision.

No month in any quarter is counted as time elapsed in determin-

ing insurance status or the average monthly wage if that quarter falls in a "period of disability" and no income received in or credited to any quarter included in a period of disability is counted in computing the average monthly wage, unless the quarter is also a quarter of coverage. In some cases enough income may have been received, or credited, in the initial or last quarters of a period of disability to make them, or one of them, quarters of coverage. A special rule is applicable in case of farm workers. If assigning quarters of coverage to agricultural workers as provided when wages for the year are less than \$400 results in failure to confer either fully or currently insured status, and if assigning different quarters would give insured status, then they may be so assigned, even to quarters in a period of disability.

Disability is defined to mean "(A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration, or (B) blindness." Blindness, in turn, means "central visual acuity of 5/200 or less in the better eye with the use of a correcting lense." An eye with a visual field reduced to five degrees concentric contraction is considered as having visual acuity of 5/200 or less. There is no definition of what is meant by substantial gainful activity nor are general criteria laid down by which such activity is to be determined. Proof of disability as required must be supplied. But there is to be no federal interference with medical practice or doctor-patient relationships, and there is to be no supervision or control over the administration or operation of any hospital.

A "period of disability" means not less than six full consecutive calendar months of disability as defined above. It is measured in quarters, because the insured person's records are kept in terms of quarters. In order to qualify for a period of disability, an individual must meet two coverage requirements. He must be currently insured, i.e., have acquired at least six quarters of coverage in the 13-quarter period ending with the quarter in which the period of disability begins. In addition to being currently insured, he must have acquired a minimum of 20 quarters of coverage in the 40-quarter period ending with the quarter in which the period of disability begins. If he cannot meet these two requirements he simply does not qualify for a period of disability. If he does have the necessary coverage and has filed an application for a disability determina-

tion (this must be filed while he is under the disability), his period of disability will begin either with the day the disability began or with the first day of the one-year period ending with the day before that on which the application was filed, whichever is later. A period of disability beginning after retirement age is disregarded.

Assume, for example, that a person having the necessary coverage is permanently totally disabled on July 4, 1956. If the application for a disability determination is filed at any time before July 5 of the following year the period will begin on the date the disability occurred. But if the application is filed on say September 7, 1957, the disability period will begin on September 7, 1956. Prompt filing of the application by persons who meet all the other requirements means that the disability period will begin with the day the disability began.

Congress set July 1, 1955, as the date for the disability feature to become operative. Most persons who came into the system before the 1950 amendments extended the Act to include 10 million more persons, beginning January 1, 1951, could qualify under the 6-in-13 and 20-in-40 requirements if already totally disabled on July 1, 1955. But many who were first brought into the system beginning in 1951 could not. For 20 quarters would not have elapsed until January 1, 1956. Special provision is made for them. Those persons under a total disability which began before July 1, 1956, were authorized to file an application at any time in the period January 1, 1955–June 30, 1957. The disability must have continued without interruption to the date of filing and, because the effective date of the disability provision was set at July 1, 1955, applications of persons dying before that date are not valid.

Thus a person newly covered beginning January 1, 1951, who acquired 20 quarters of coverage in the five years 1951–1955, and who became permanently totally disabled before July 1, 1956, will have met all coverage requirements for a disability determination. His total disability would have to continue for six months before the Act's definition of disability could be satisfied, which in the above example could at the earliest be December 31, 1956. If he files an application at any time before July 1, 1957, the beginning of his period of disability will be the day the disability began. Should the person fail to file his application until after June 30, 1957, the beginning of his disability period would be postponed. The postponement is in terms of quarters, because the entire quarter in a period of dis-

ability is omitted in computing benefits, unless it is also a quarter of coverage.

A period of disability ends when the disabled person attains retirement age or recovers from the disability. More precisely, it ends with the close of the last day of the first month in which either of these two events occurs. For a person reaching retirement age or recovering on, say August 13, the period of disability would end at the close of August 31. The entire quarter would be eliminated if it was not also a quarter of coverage.

The determination of whether an applicant is under permanent total disability and the day on which it began and the day on which it ceases is to be made in each instance by state agencies pursuant to agreements made by the Secretary of Health, Education, and Welfare and the states willing to participate. The Act refers to the state agency administering a plan approved under the Vocational Rehabilitation Act, but any other appropriate agency may be used, such as the agency administering Federally subsidized aid to the blind and the agency administering the state's workmen's compensation law. Each of these has had experience in dealing with permanent and total disability. However, the Secretary is empowered, after reasonable notice and hearing, to review a state determination and to determine that an individual applicant deemed disabled by the state agency is in fact not disabled, or that the disability began on a date later or ceased on a date earlier than the one determined by the state agency. The Secretary is not empowered to determine that an individual is in fact disabled if the state agency has ruled that he is not, or that his disability began at an earlier date or ceased at a later date than the one determined by the agency. An applicant dissatisfied with the determination made in his case may appeal to the Secretary and beyond that to the Federal courts. In states where there is no agreement and in the case of individuals outside the United States, determinations are made by the Secretary. The expense of making disability determinations is borne by the Federal Old-Age and Survivors Insurance system. Standards for the control of these expenses are not laid down in the law.

Dependents' and Survivors' Benefits. These, then, are the conditions under which the primary benefit is paid and the basic methods used for computing the amount. The primary benefit is payable only to fully insured persons who are at least 65 years old. A comprehensive set of benefits is provided for those who are de-

pendent upon retired insured persons and for those who survive them in case of death. The benefit amounts paid to the dependents and survivors of insured persons are all stated as fractions of the primary benefit.

Wife's and Husband's Benefit. A woman whose husband is entitled to a primary benefit, who is at least 65 years old, or if not 65 has in her care a child of his entitled to a child's benefit, and who has filed application for it is entitled to a wife's benefit equal in amount to one-half her husband's primary benefit. The child's benefit and the conditions under which it is payable will be described below. The wife must have borne her husband a child or have been married to him at least three years immediately preceding her application, she must be living with or be receiving support from him when the application is filed, and she must not be entitled on her own account to a primary benefit greater than the wife's benefit. If she were so entitled, she would receive her primary benefit. The wife's benefit ceases when her husband dies, if they are divorced, if she dies, or when the youngest child is no longer entitled to a benefit if the wife is then not yet 65 years old.

An insured woman's husband may receive a benefit, computed in the same manner as a wife's benefit. To qualify, he must be at least 65, be dependent upon her for at least one-half of his support, and be the father of her child or have been married to her for at least three years. She must be entitled to a primary benefit, which means that she has attained age 65, is fully insured, and has applied for her benefit. But in addition she must also be currently insured, i.e., have met the 6-in-13 quarters of coverage requirement. Thus an extra burden is imposed on the woman whose husband is to receive a benefit based on her earnings. The husband's benefit is terminated under the same conditions as the wife's benefit is.

Widow's and Widower's Benefit. The widow of a man who died fully insured is entitled to a benefit equal in amount to three-fourths of his primary benefit if she has attained retirement age, i.e., 65, has not remarried, has filed an application unless she was entitled to a wife's or mother's benefit for the month before she attained retirement age, and was living with or being supported by him at the time of his death. To qualify as a widow, she must have borne him a child, or have adopted his child before it was 18 and while she was married to him, or have been married to him when they both adopted a child under 18, or have been married to him at least one

year before his death. The benefit is terminated if she remarries or becomes entitled to a primary benefit on her own account which is greater than her widow's benefit.

A widower may likewise receive a similar benefit under the same conditions, but only if his wife was both fully and currently insured and then only if he was dependent upon her for one-half or more of his support at the time of her death.

Mother's Benefit. A woman whose husband died either fully or currently insured, is entitled to a mother's benefit equal in amount to three-fourths of his primary benefit if she has in her care a child of his, by blood or adoption, who is entitled to a child's benefit, provided she is not entitled to a primary benefit equal to or greater than the mother's benefit, or to a widow's benefit, and provided also that she has not remarried, was living with or being supported by him at the time of his death, and has filed an application for the benefit unless she was already entitled to a wife's benefit. It terminates when she no longer has in her care a child of his who is entitled to a child's benefit, when she remarries, when on her own account she becomes entitled to a primary benefit larger in amount than the mother's benefit, or when she becomes entitled to a widow's benefit. She will have to attain age 65 before she is entitled to a widow's benefit. For a number of years, then, after her youngest child is 18 and before she is 65, a widow is without any benefit. A "former wife divorced" of the same man is entitled to the benefit under the same conditions except that of cohabitation, but she must have been receiving at least one-half of her support from him, and the child in her care must also be hers as well as his, by blood or adoption.

Child's Benefit. Every child of a man or woman who is entitled to a primary benefit or who dies either fully or currently insured is entitled to a benefit if at the time the insured parent died or became entitled the child was under 18, unmarried, and dependent upon the insured parent. If the insured parent is living, a stepchild or an adopted one qualifies for the benefit if it became such at least three years before its application is filed. If the insured parent is deceased an adopted child under 18 qualifies without regard to time of adoption, but a stepchild must have been a stepchild for at least one year before the insured's death in order to qualify.

If the insured parent is living and entitled to a primary benefit,

each child's benefit is equal in amount to one-half of the primary benefit. If the parent has died, the amount is computed differently. When only one child is entitled to a benefit, the amount is three-fourths of the primary benefit. If there are two or more children, the amount for each is one-half the primary benefit plus an additional amount equal to one-fourth of the primary benefit divided by the number of children. Thus if there are two children each one's benefit will be equal to five-eighths of the primary benefit.

A child is normally deemed dependent upon its father unless it is neither legitimate nor adopted, has been adopted by someone else, or was receiving more than one-half of its support from a stepfather. If the benefit is based on the mother's earnings, a child is deemed dependent upon its mother if she was currently insured at the time of her death. If she was not currently insured the child is nevertheless deemed dependent upon its mother if it was living with or being supported in part by her and not living with its father or receiving as much as one-half of its support from him. The child's benefit ceases when it reaches 18, if it marries before 18, or if it is adopted by anyone except a stepparent, grandparent, aunt, or uncle after the insured's death.

Parent's Benefit. There is also a benefit, equal in amount to three-fourths of the primary benefit, payable to each parent of an individual who died fully insured and who was not survived by a widow, widower, or child entitled to a monthly benefit based on his earnings. But the parent must be at least 65 years old, must have been dependent upon the deceased for at least one-half of his support, and must not have remarried since the deceased's death. In order to qualify, a stepparent or adoptive parent must have become such before the deceased was 16 years of age.

Death Benefit. On the death of every fully or currently insured person, a lump-sum payment is made to the surviving widow or widower, or if there is none, to the person or persons "equitably" entitled to it to the extent and in proportion to which that person or persons paid the deceased's burial expenses. The amount is \$255 or three times the primary benefit amount, whichever is the smaller. A widow or widower entitled to a wife's or husband's benefit for the month preceding the insured's death need not make application in order to be entitled to the lump-sum benefit. Otherwise application for it must be made within two years of the insured's death.

Limitations and Deductions. Each benefit described above is payable under the conditions specified in the Act, and the amount of each is computed in the manner described. But there are limitations on the total amount that will be paid when several benefits based on the income of one primary beneficiary or insured person are payable. Furthermore, under certain conditions, benefits which otherwise would be paid are withheld.

Reductions. When two or more monthly benefits are payable on the basis of one insured person's earnings, as for example an old-age, a wife's, and a child's benefit, the sum of the individual monthly benefits computed as explained above may be reduced. If the total is more than \$50 and if it also exceeds 80 percent of the insured person's average monthly wage, then the total will be reduced to 80 percent of the average monthly wage or to one and one-half times the insured person's primary insurance amount, whichever is the greater. But in no case will the total be reduced below \$50. Furthermore, if one or more of the beneficiaries is a child whose father and mother had died fully or currently insured, the total will not be reduced below 80 percent of the sum of the average monthly wages of both parents. However, if the total still exceeds \$200 after this reduction is made, then the total will be reduced to \$200. Thus no family can receive more than \$200 a month on the basis of one insured person's earnings. When a reduction in the total amount of benefits is necessary, each one is reduced proportionately, except that the primary benefit itself is never reduced.

Assume, for example, that an insured man with an average monthly wage of \$250 and a primary insurance amount of \$88.50 dies, leaving a widow and three children entitled to benefits. Her unreduced benefit will be \$66.38 and each child's unreduced benefit will be \$51.63. The unreduced total for all will be \$221.27. This exceeds both 80 percent of the average monthly wage and one and one-half times the primary insurance amount, and it exceeds the absolute maximum of \$200. It will have to be reduced to \$200. Ten parts are involved: three fourths for the mother and seven fourths for the children combined, and each part of the \$21.27 is \$2.126. Reducing the mother's benefit by three parts leaves it at \$60, and reducing the children's benefits by seven parts leaves their total at \$140. In most cases a single check for the maximum total amount allowed is issued. When the oldest child reaches 18, the benefits are

recomputed. The mother will receive \$66.38 and each child \$55.31; this is less than any prescribed maximum and therefore they receive the full amount of their benefits for that combination of beneficiaries. When the second child is 18, the mother and the remaining child will each get \$66.38. It should be noted here that when any reduced benefit is not a multiple of ten cents, it is "rounded" by raising it to the next higher multiple of ten cents, even though the specified maximum is thereby exceeded. That was not done in the example just given. When the third child reaches 18, all benefits cease. If the deceased husband was fully insured and if the mother meets the required conditions, she will become entitled to a widow's benefit at age 65.

Deductions. Beneficiaries under age 72 are permitted to earn as wages or self-employment income or both combined as much as \$1200 a year without suffering any loss of their benefits. Earnings above \$1200 must be reported to the Secretary of Health, Education, and Welfare, on or before the fifteenth day of the third month following the close of the tax year. They will be charged against the beneficiary at the rate of \$80 per month, beginning with the last month of the year. The general rule is that the monthly benefit will be withheld (deducted) for every month charged with \$80 or any fraction thereof. But there is a saving clause to the effect that nothing at all will be charged to any month in which the beneficiary did not actually earn *more* than \$80 or in which he did not render "substantial services" as a self-employed person, or for any month in which the beneficiary for some reason other than excess earnings was not eligible to receive the benefit. Methods and criteria for determining whether a beneficiary has rendered "substantial services" are prescribed by the Secretary. Before 1955, a beneficiary could earn any amount in wages and self-employment income in employment not covered by the Old-Age and Survivors system. That certainly was not compatible with the basic principle of a retirement system, and it resulted in some inequity as between beneficiaries. Now all earnings in the United States, whether in covered or uncovered employment, and in covered employment outside the United States are counted in determining whether benefits are to be denied. Beneficiaries working at least seven days in any month in noncovered employment outside the United States lose their benefit for that month irrespective of the amount of their earnings.

Suppose, for example, that a beneficiary under 72 entitled to a monthly benefit of \$70 earns \$3000 in a year. He is entitled to \$1200 a year in wages or self-employment income without penalty. The excess above \$3000 is \$1800. The beneficiary may therefore be charged with \$80 for each of the 12 months. Anyone reporting earnings of more than \$880 in excess of the \$1200 base will be presumed to have received at least \$80 in 11 months of the year and \$80 or a fraction thereof in the twelfth. But if he produces evidence satisfactory to the Secretary that the \$1800 was earned in say four months of the year, or if he is not a wage earner that he engaged in self-employment in only four months, then nothing will be charged to eight months in that year, and he will receive his benefit for those eight months. Wage reports from employers, book royalty statements from publishers to authors for works already published, and acceptable statements from partnerships to the effect that a beneficiary participated in profits without rendering services or participated only in specified months constitute evidence that might be satisfactory to the Secretary. Thus it is now possible for beneficiaries under 72 to be employed full-time at high wages or self-employment income for a short period of time or steadily engaged throughout the year at low rates without losing any benefits. Beneficiaries who are 72 or older may earn any amount and still receive their benefits, and they need not report excess earnings.

When a primary beneficiary's benefit for any month is deducted because the beneficiary's earnings exceed the prescribed maximum, benefits otherwise payable to a wife, husband, or child based on the insured's earnings are also deducted. If the primary beneficiary's earnings do not exceed the prescribed maximum but those of any of his dependents do, then only the benefits of those dependents with earnings in excess of the maximum would be deducted.

Failure to make timely reports of earnings above the \$1200 base, unless for good cause, will lead to additional deductions. For the first failure to report the additional deduction will equal the amount of the last monthly benefit of the year. For the second failure it will be twice that amount, and three times that amount for the third failure. However, the number of additional deductions is not to exceed the number of months in the year for which the beneficiary received and accepted benefits he should have forfeited for failing to report on time. The beneficiary will be required to file an estimate of self-employment earnings above \$1200 in his tax year if there

is reason to suppose that the excess will be sufficient to justify deductions.

Veterans. Persons who served in the armed forces between September 16, 1940, and July 1, 1953, and who were discharged or released other than dishonorably after a minimum of 90 days of active duty, or were released with less than 90 days of service because of illness or injury incurred in or aggravated by that duty, are deemed to have been paid wages of \$160, in addition to any covered wages actually received, for each month during any part of which they were on active duty. This means that those on active duty acquire quarters of coverage which may be used to determine insurance status and also wage credits on which benefit amounts may be computed. They may be used also to determine whether the veteran satisfies the 6-in-13 and 20-in-40 coverage requirements in case of permanent total disability. Coverage and credits are not counted if the veteran or his dependents are receiving periodic payments, or a lump-sum commutation of or substitute for them, based in whole or in part on that active duty, from any Federal agency or instrumentality other than the Veterans Administration. Credits for the military service may not be counted, for example, in computing both a civil service retirement benefit and an Old-Age and Survivors Insurance benefit. In case of death within three years immediately following separation from service, veterans of World War II were deemed to have been fully insured, thus making benefits available to their dependents. The entire cost is borne by the United States Government. However, because servicemen are generally young, relatively few of them will benefit and the cost will not be great.

Taxes. Federal Old-Age and Survivors benefits are financed by special taxes. Employers and their employees pay equally. Until 1950, the rate was 1 percent for each. For 1950-1953 the rate was increased to 1½ percent, for 1954-1959 it is set at 2 percent, for 1960-1964 at 2½ percent, for 1965-1969 at 3 percent, for 1970-1974 at 3½ percent, and 4 percent thereafter, unless changed by Congress. The rate for self-employed persons was set at 2½ percent for 1951-1953, and at 3, 3½, 4½, 5½ and 6 percent respectively for the succeeding periods. Thus the self-employed pay only 50 percent more than the tax levied on wage earners, or three-fourths of the combined total levied on employers and wage earners.

Wages, for purposes of the Act, include cash payments and, ex-

cept as specified, also remuneration paid in any other medium. But amounts above \$4200 for any individual in a year are not taxed; until 1951, the maximum was \$3000, and then until the 1954 amendments it was \$3600. Some payments made by employers to or on behalf of employees are not considered as wages. Employer contributions to private social security funds for the benefit of employees and their dependents, and taxes levied on employees by the Federal Old-Age and Survivors law and under state unemployment insurance and workmen's compensation laws, which are paid by the employer and not deducted from the employees' wages, are not taxed. Likewise excluded are payments of wages or medical or hospitalization expenses to or on behalf of disabled employees after six months following the beginning of the disability, and wages and retirement benefits paid to retired employees who have attained age 65 and who render no services to the employer. The value of payments in kind to farm workers and domestic servants is specifically excluded; and wage payments of less than \$50 in any quarter made to household, farm, and "home" workers, it will be recalled, are not counted.

Self-employment income consists of net earnings, other than wages, derived from a trade or business and, with some exceptions, from a profession. But amounts above \$4200 and incomes of less than \$400 in any one year are not taxed. The law specifically excludes any income derived from the rental of real estate, including income from personal property rented with real estate and rentals paid in crop shares, unless that income is received by real estate dealers in the course of their trade or business. Also excluded are dividends on corporation stocks, and interest on bonds or other evidences of indebtedness issued by corporations or governmental units, unless received by a dealer in securities in the course of his trade or business. Capital gains and losses are not counted in computing income. Not counted also are gains or losses resulting from the disposal of property not held primarily for sale to customers in the ordinary course of the trade or business. When an individual has both wages and self-employment income amounting to a combined total of more than \$4200, only the difference between his wages and \$4200 is taxable as self-employment income, and it is taxable even though it amounts to less than \$400.

Special provision is made for farm operators. A farm operator re-

porting on a cash basis whose annual net earnings from the farm amount to at least \$400 and whose gross farm income does not exceed \$1800 may return the actual amount of net earnings or 50 percent of the gross income. But if the gross income is more than \$1800 he may report either \$900 as net earnings or the actual amount if it is greater or less than \$900.

The employer deducts the employee's tax, adds his own, and sends the total to the Treasury quarterly. Amounts taxed are credited to the insured person's individual account, which is kept in Baltimore. Should any employee receive wages from two or more employers, each employer deducts the tax due on the wages he pays to that employee, but the employee may recover taxes deducted on more than a total of \$4200 in one year. Neither employer in this case could recover any part of the tax on wages above a combined total of \$4200.

Self-employed persons receiving \$400 or more net income in any taxable year fill out a social-security schedule in their annual income-tax return and pay the prescribed rate on their taxable net income. Self-employment income is credited in equal amounts to each quarter of the tax year. Thus a person with \$400 of taxable self-employment income will get four quarters of coverage for the year, even though all the income has been earned in one quarter, or even in one month, except possibly when part of a disability period is included in that year.

Under the law as it stood before the amendments of 1950, the Federal government was pledged to pay the difference between the system's revenues and expenditures, should a deficit develop. This was interpreted by many to mean acceptance of the principle that government contributions eventually would become a standard feature of the system. However, the provision was dropped in the 1950 amendments. The system is therefore strictly on its own, at least for the time being.

The taxes on pay-roll and self-employment income are collected by the Bureau of Internal Revenue. All the money collected goes into the general revenue fund and not into a separate account. Congress then appropriates all the money received in taxes, penalties, and interest for the Old-Age and Survivors Insurance Trust Fund, which is managed by a Board of Trustees consisting of the Secretary of Labor, the Federal Security Administrator, and the Secretary of

the Treasury, who is the "managing trustee." Benefits and expenses of operating the plan are paid from these funds. Whatever remains is invested in United States government obligations, either bonds already issued or new bonds especially issued for investment of these funds. Should it become necessary, the Secretary of the Treasury, as managing trustee, may sell bonds to secure current funds with which to pay benefits. Interest on government bonds acquired by the Trust Fund is added to the fund.

To guard against the possibility of deficits or excessive surpluses, it is provided that the Board of Trustees must report to the Congress when it believes that during the next ensuing five fiscal years the Trust Fund will exceed three times the highest annual expenditures anticipated during that five-year period; it must also report whenever it believes that the amount in the Trust Fund is "unduly" small. Presumably the Congress would then act to correct the situation by changing rates or benefits or both, or by granting a subsidy if that were necessary.

Reconsideration, Hearings, and Appeals. In a system as large and complicated as this one is, some disputes inevitably develop. Hence provision is made to handle such disputes.

Any decision concerning wage credits or benefits may be reconsidered if the person concerned so requests. Palpable errors, of which there are relatively few, can be corrected in this way. If the person concerned prefers, a hearing may be held, presided over by a referee provided by the system. Requests for hearings must be made in writing and must be made within six months after the original decision was rendered.

Beyond the hearing, there is recourse to a review by the Appeals Council in Washington, D.C. This must be requested by the person concerned within 30 days after the referee's decision. The Appeals Council will review the record and will make its decision on the basis of that record. The Council is independent of the Bureau of Old-Age and Survivors Insurance, which administers the system of benefits.

Appeal from decisions of the Appeals Council may be taken to the Federal courts. Such civil actions must be filed within 60 days after the Appeals Council has mailed its decision, unless the Social Security Administration allows additional time. The decision of the United States Supreme Court, if the case goes that high, is final.

THE ORIGINAL SYSTEM

The Old-Age insurance system established in the original Social Security Act of 1935 differed quite drastically from the one now in effect, which was established by amendments made in 1939, 1950, 1952, and 1954. A brief description of the original system will indicate how drastic the changes were and how much more comprehensive and adequate the present system is.

Coverage. Employments and employees covered by the original act were substantially the same as in the present one, and need not be described here. One important difference is that persons 65 or over were not included in the original plan. Their wages were not taxed; if they had not qualified for a monthly benefit at age 65 they could not thereafter qualify; and those who did qualify could not increase their benefit amounts by continuing to work in covered employment.

Benefits. Only one monthly benefit was provided in the original plan, payable to the insured worker who met all the conditions laid down for eligibility. Conditions for eligibility were simple and relatively easy to meet. It was required that there must have been employment in covered industries on at least five days, each day being in a different calendar year after December 31, 1936. Monthly benefits would have begun in 1942. The worker must have earned at least \$2000 in covered employment after December 31, 1936, and before attaining age 65. He must also have reached age 65 and must have retired from regular employment. For each month after age 65 in which an insured worker received wages in "regular" employment, the benefit would not be payable. This went farther than the restriction in the present system.

The amount of the monthly benefit was to be based on wages earned in covered employment, not counting amounts in excess of \$3000 per year or amounts earned after age 65, and was to be determined as follows. On the first \$3000 of total covered wages, one-half of 1 percent would be paid; on amounts between \$3000 and \$45,000, one-twelfth of 1 percent; and on amounts above \$45,000, one-twenty-fourth of 1 percent. Assuming, for example, that a worker had total covered wages of \$100,000, then on the first \$3000 he would receive \$15, on the next \$42,000 he would receive \$35; on the remaining \$55,000 he would receive \$22.92; the total monthly benefit would be \$72.92.

The law specified that no monthly benefit should exceed \$85. This is the amount that would be yielded by total wages of \$129,000, or \$3000 per year for 43 years. The minimum would automatically be \$10, since no one with less than a total of \$2000 in covered wages would be eligible for a monthly benefit, and one-half of 1 percent of that amount is \$10.

For those who did not qualify for a monthly benefit, the law provided that a lump sum equal to 3.5 percent of total taxable wages would be paid to them upon attaining age 65. If an insured person died before he reached age 65, or after age 65 and before he had received in monthly benefits at least 3.5 percent of his total covered wages, then his estate would receive an amount equal to 3.5 percent of total covered wages or the difference between what he had received in benefits and 3.5 percent of those wages. This guaranteed to the worker a return of at least the entire amount he himself paid into the system, accumulated at interest. Dependents of deceased workers had only the protection provided by the lump-sum payment made when their breadwinner died. Any excess above this 3.5 percent paid in monthly benefits would have come from the contributions made by the employers.

Taxes. The cost of the system was in a sense made a charge on the Federal government. Authority was granted to appropriate "an amount sufficient as an annual premium to provide for the payments required under this title," the amount to be determined on a "reserve basis in accordance with accepted actuarial principles . . . and upon an interest rate of 3 percentum per annum compounded annually."

However, special pay-roll taxes were levied on employers and employees, and it was fully expected that the proceeds from these taxes would meet the entire cost of the system. For three years beginning with 1937, the rate was to be 1 percent on each, levied on wages not in excess of \$3000 per year from any one employer, and for each three years thereafter it was to be raised one-half of 1 percent until the total reached 3 percent on each, or 6 percent combined, in 1949. A lively controversy developed over the reserve that would have been built up. The Senate Committee on Finance estimated that by 1980 the reserve would be just under \$47 billion. Fears concerning the effects of such a large accumulation on the economy and on Federal fiscal affairs were expressed by many.

Administration. The system was administered by the Social Security Board, the same three-man agency which administered the present system until it was replaced by the Social Security Administration. Taxes were collected by the Bureau of Internal Revenue, and reserve funds were invested in Federal obligations by the Secretary of the Treasury.

CHAPTER FIVE

THE FEDERAL OLD-AGE AND SURVIVORS INSURANCE SYSTEM: OPERATIONS

THE Federal Old-Age and Survivors Insurance system was established to assist as many as possible to live out their declining years on income received as a matter of right rather than as public or private relief. The extent to which it succeeds will be revealed in the figures showing its operations. The system is still in its infancy and will not reach maturity for many years. Yet operations to date will show what the present situation is and should also give a fair idea of developing patterns. It will be worth while therefore to review briefly some of the latest summary data available.

COVERAGE

It will be recalled that some employments are specifically excluded from the system. In reviewing the figures showing the numbers engaged in excluded employments, it should be remembered that many of those employments are included in other governmental retirement systems, notably the United States Civil Service, the Railroad Retirement, and teacher retirement systems. State and local governments also have retirement systems, as have many private employers. Furthermore, many persons in excluded employments have at one time or another been in covered employment and have acquired rights in the system. Indeed, some of them are on the Federal Old-Age and Survivors Insurance system's benefit roll.

Exclusions. Before the 1950 amendments, some 24 million workers were normally engaged in occupations specifically excluded from coverage. The largest single group consisted of approximately

12 million self-employed persons—one-half of the total. One-fourth were government workers, many of whom were covered by their own plans. The remainder were agricultural, household, and railroad workers. The railroad workers have long had a system of their own.

Many who clamored for and received exclusions when the system was first established sought coverage later.¹ The earlier concern about collecting taxes and wage records from employers of household and agricultural workers weakened, because most of those employers are accustomed to keeping records and making income-tax returns. Nearly 10 million were brought under coverage by the 1950 amendments. Of those compulsorily included, there were 4,750,000 self-employed, 850,000 agricultural workers, 1,000,000 household employees, 250,000 Federal civilian employees not under any retirement system, 150,000 employees outside the United States, 400,000 in Puerto Rico and the Virgin Islands, and 400,000 now considered employees under a broader definition of the term. Voluntary coverage has been assumed for about 600,000 employees of nonprofit organizations and 1,500,000 state and local employees.

Pressure for the expansion of coverage was eased only momentarily by the amendments of 1950. In 1954, Congress included farm operators and some self-employed professional persons as well. Clergymen, American employees of foreign subsidiaries of domestic corporations, and local and state employees already covered by a retirement system may now be included by election. The number now excluded and who are not in some other governmental system is practically negligible.

Inclusions. Comprehensive data are available to show the numbers of workers engaged in covered employments.

Employers. Because they report wages and collect taxes, it will be worth while to indicate the number of employers making returns. Table 7 gives the number of tax returns made by employers since 1937. The data do not give the exact number of different employers required to pay taxes, for some who have several establishments make separate returns for each establishment. However, the data do show that the number of taxable employers has consistently been large, roughly amounting to 4 million, and that the number in-

¹ *Hearings on Social Security Legislation*, before the House Committee on Ways and Means, 79th Congress, 2nd Sess. vol. 1, Old-Age and Survivors' Insurance

creased only slightly until the marked postwar expansion which began in 1946. Before that, annual variations had been minor and were occasioned mostly by the coming and going of small employers. The marked increase recorded for 1951 reflects the new coverage resulting from the amendments of 1950. The numbers of employers reporting very likely will continue to increase slowly.

TABLE 7. Federal Old-Age and Survivors Insurance: Estimated Number of Employers, Workers, and Taxable Wages, by Year, 1937-1952 ²

Year	Employers Reporting Taxable Wages (Thousands) ^a	Workers with Taxable Wages (Thousands)	Taxable Wages	
			Total (Millions)	Average per Worker
1937	2421	32,904	\$ 29,615	\$ 900
1938	2239	31,822	26,502	833
1939	2366	33,751	29,745	881
1940	2500	35,393	32,974	932
1941	2646	40,976	41,848	1021
1942	2655	46,363	52,939	1142
1943	2394	47,656	62,423	1310
1944	2469	46,296	64,426	1392
1945	2614	46,392	62,945	1357
1946	3017	48,845	69,088	1414
1947	3246	48,908	78,372	1602
1948	3298	49,018	84,122	1716
1949	3316	46,796	81,808	1748
1950 ^b	3340	48,100	87,498	1819
1951 ^b	4440	58,000	120,100	2071
1952 ^b	4430	60,000	128,000	2133

^a Number corresponds to number of employer returns. A return may relate to more than one establishment if employer operates several separate establishments but reports for concern as a whole.

^b Preliminary.

Employees. The system began in 1937 with a coverage of nearly 33 million employees. The number with taxable wages declined slightly during the business recession of 1938-1939, and then grew to a total of 47.7 million in 1943. That tremendous expansion was the result of the growth of war industries, in which millions who had never before worked in industry took jobs. A small sample study

² *Social Security Bulletins.*

made during January 7–February 5, 1943, showed that about 41 percent of those entering the system were housewives, 29 percent schoolchildren, mostly boys, 8 percent urban self-employed, 8 percent government workers, 7 percent domestic help, 6 percent agricultural workers, and 1 percent retired persons.³ In 1944, for the first time since 1938, there was a slight decline, which was a reflection of the growth of our armed forces and a slight decline in total employment. But the upward trend was again resumed in the following year, reached 60 million in 1952, and it may be expected to continue over a long period of time, with perhaps minor reversals, until the nation's working force becomes stabilized.

Movement In and Out. There is considerable movement of workers into and out of the system. Of the nearly 33 million covered in 1937, about 5.6 million were not in covered employment in 1938 and about 4 million of those on the 1938 list were not in covered employment in 1937.⁴ In the six years 1937–1942, about 60 million different persons earned some wages in covered employment and paid their taxes. A sample study of those 60 million showed that only 32 percent had worked in covered employment in each of the six years. In addition to these, 9.1 percent had worked in five of the six years. Only 9.7 percent had worked in each of four years, and 11 percent in each of three years. Of the 60 million, 16 percent had worked in two of the six years, and 22 percent in only one year.⁵

During 1943 a peak of 47.7 million different individuals worked in covered employment, but at any given time in that year there were never more than 31 million employed. The number of different individuals employed in 1946 went up to 49.8 million and to 50 million in 1947. By the end of September 1946 a total of 86.2 million employee accounts had been established, and there were 77 million living persons with account numbers, which amounted to 71 percent of the living population 14 years of age and over. Approximately 80 percent of all employed persons in this country are in jobs covered by the system.

There are many reasons for the movement into and out of the system. Most important for the years 1940–1946 was the great flow of workers into and out of defense and war industries. Also, many women normally work in industry and commerce for only short

³ *Social Security Bulletin*, June 1943, pp. 50–52.

⁴ *Ibid.*, December 1940, pp. 3–10.

⁵ *Ibid.*, July 1944, pp. 37–38.

periods of time before establishing homes. During any given period of years there would also be many young people just beginning their careers. Some work a few years for wages and then become employees in noncovered employment or become employers or self-employed. And finally, retirement, death, and disability normally remove many from employment.

Age, Race, and Sex. The percentage distribution of covered workers by age intervals for specified years is given in the following figures.⁶

Age	1940	1942	1944	1946	1951
Under 20	8.4	13.3	14.9	10.3	9.0
20 - 29	34.6	29.7	23.5	29.4	25.3
30 - 39	25.0	23.9	23.0	23.4	24.0
40 - 49	17.1	17.1	19.0	16.6	20.0
50 - 59	10.3	10.9	12.7	11.4	13.5
60 - 69	3.9	4.4	6.9 *	6.1	6.8
70 and over	0.7	0.7	—	1.7	1.4

* 65 and over.

Nearly 87 percent of those covered in 1942 were 20 years of age or older, and the percentage was higher in 1946. The percentage of those under 20 increased appreciably during the war years, because many youngsters went into war work, some of them neglecting their schooling to do so. Many men between 20 and 40 years of age went into the armed forces, which explains the declines in percentages for these two age groups during the war years, and the continued employment of large numbers of older workers accounts for their further decline in 1946. The other groups showed but little relative change, although there was a slight increase in the group 60-69 during the war years and a marked increase in postwar years. These percentage changes should be considered in connection with the absolute increase of many millions employed in covered industries. Thus although there was practically no relative change in those 70 and over until after the war, there was an absolute increase of 77,000. Our high birth rate will have a marked effect on percentage distributions in the near future.

The age distributions of workers in the different industries vary

⁶ *Ibid.*, March 1945, p. 11; *Social Security Yearbook, 1946; Analysis of Social Security System*, Hearings before a subcommittee of the Committee on Ways and Means, House of Representatives, 83rd Congress, 1st Session, Appendix I, p. 1089.

quite considerably, as the following data for 1944 show.⁷ For men, the median age was highest, 46.7, in the broad industry division of finance, insurance, and real estate. Next came contract construction, where the median was 41.3 and mining, where it was 40.5. In manufacturing it was 38.6, and in public utilities and trade it was 37.4. Service industries ranked next with 37.2. There was a wide range in major industry groups within these broad divisions. Real estate topped the list with a median age of 50.2, and recreation and related services was the lowest, with a median somewhat above 21.

For women, the picture was quite different. Women workers are in general appreciably younger than men, approximately 10 years for all occupations. The median age for women was highest in the service industries, where it was 31.1. This was followed by contract construction, where it was 30.3, manufacturing with 29.8, and finance, insurance and real estate with 29.6. In mining, public utilities, and trade, the median age was approximately 27.5. The highest median age for women was in nonprofit membership organizations and institutions, where it was 35.5, and the lowest was in retail general merchandise, with 23.9.

The year 1944 was not typical, for because of the war some industries had expanded and others had contracted, the proportion of men and women from 20 to 34 was relatively low, and the proportions under 20 and over 35 were relatively high. Reconversion and demobilization have changed the distributions somewhat, as has the decline in the employment of older women since 1945. The data given here, however, are suggestive.

A percentage distribution of covered employees by race and sex for the years 1940-1942 is given below. The figures for whites include all races other than Negro.⁸

Race and Sex	1940	1941	1942
White male	66.5	65.5	62.3
White female	26.6	27.0	29.3
Negro male	5.8	6.3	6.6
Negro female	1.1	1.2	1.8

Until recently over 90 percent of those covered were whites. Negroes are for the most part employed in agricultural pursuits and

⁷ See George H. Trafton, "Age Distribution of Workers in Industries Under Old-Age and Survivors Insurance," *Social Security Bulletin*, March 1947, pp. 13-20. The figures given are estimates from a 1 percent sample.

⁸ *Social Security Bulletin*, March 1945, p. 11.

domestic service, both of which were excluded from coverage. During the war years, the percentages of females and Negroes covered increased, owing to expansion in employment and to the desperate need for additional man power. By 1942, the proportion of Negroes in covered employment was not much below the proportion of Negroes in the labor force. The amendments of 1950 and 1954, especially by extending coverage to agriculture and domestic service, have largely, but not wholly, eliminated the disadvantage in coverage suffered by Negroes. Females, both white and colored, are entering covered employment in relatively larger numbers than males and will no doubt for some years constitute an increasingly large proportion of the workers in covered employment.⁹

WAGES

Benefits in the Old-Age and Survivors Insurance system are based on the amount of wages earned in covered employment. The level of covered wages and the movement of the level from year to year are therefore important. The proportion of covered wages and salaries to total wages and salaries gives a fair idea of the extent of existing coverage.

Total Covered Wages. Taxable wages increased 300 percent from 1937 to 1952, going from \$29.6 billion to \$128 billion, as is shown in Table 7. Every year from 1939 through 1947, except 1945 and 1950, showed an increase in the total. The marked yearly increases of approximately \$9 billion in 1941, 1942, and 1943 were the result of defense and war employment, higher wage rates, and penalty overtime. Full employment and increasing wage rates characterized the years after 1945. Although the total number of persons in covered employment went down about 2.2 percent in 1944, and average weekly hours declined, total taxable wages continued to go up. The average taxable wage per worker rose from \$900 in 1937 to \$2133 in 1952 and increased every year from 1939 through 1952, except in 1945 for which year there was a slight decline. Both average and total taxable wages went up in 1952 because of expanded coverage.

The percentage of total pay roll in covered employment to all civilian wages and salaries increased from 68.4 in 1938 to 76.7 in 1942, declined to 75.0 in 1945, and increased to 76.5 in 1946. For

⁹ *Ibid.*, April 1947, p. 33.

1952, the percentage reached 83.7. The small relative increase from 1938 to 1942 is probably attributable to expanded employment and higher earnings in defense industries. The decline from 1942 to 1945 is the result of greatly expanded employment in maritime transportation and government, neither of which was covered by the system, as well as the decline of employment in covered industries in 1944 and 1945. For 1946, all civilian wages and salaries amounted to \$103.3 billion, and pay roll in covered employment increased almost \$8 billion. Total covered pay roll in 1952 was \$145 billion, the largest to that date. Expanded coverage and a growing labor force will no doubt bring still higher totals.

Distribution by Wage Intervals. Annual totals show the general movement of wages in covered employment. Table 8, which shows the number and percentage distribution of workers and amounts received, by wage intervals for 1944, throws some light on differences in wages among covered workers.

TABLE 8. Federal Old-Age and Survivors Insurance: Wages and Earnings of Covered Workers in 1944, by Wage Interval¹⁰

Wage Interval	Workers		Earnings	
	Number (Thousands)	Percentage Distribution	Amount (Millions)	Average per Worker
Total	46,296	100.0	\$72,762	\$ 1,572
\$ 1 - 999	20,428	44.1	7,197	352
1,000 - 1,999	10,908	23.6	15,731	1,442
2,000 - 2,999	7,822	16.9	19,021	2,432
3,000 - 3,999	4,483	9.7	15,260	3,404
4,000 - 5,999	2,090	4.5	9,823	4,700
6,000 - 11,999	448	1.0	3,222	7,193
12,000 or more	117	0.2	2,508	21,434

More than 44 percent received less than \$1000, the average being \$352, and their total take was \$7197 million, or just less than 10 percent of total earnings of covered workers that year. These were short-term or part-time workers, for wage rates in that year were sufficiently high to enable almost anyone fully employed to earn a very substantial income. Only 117,000, or two-tenths of 1 percent, received \$12,000 or more, the average being \$21,434, and their take

¹⁰ Adapted from *Social Security Bulletin*, May 1947, p. 26.

amounted to nearly 3.5 percent of total earnings. Those were mostly officers and executives of corporations. Those earning between \$2000 and \$4000 constituted 26.6 percent of the total number and their take amounted to slightly more than 47 percent of total earnings of covered workers.

Only the first \$3000 of any worker's wage or salary was taxed. When the system was first established, few workers received annual incomes of more than \$3000 and few of those who did so received amounts appreciably higher than that. But price and wage levels have risen considerably since 1937. As a result, the \$3000 maximum was exceeded by a large proportion of covered employees and was increased to \$3600 in 1950 and to \$4200 in 1954.

It was estimated that in 1937 only 3.1 percent of the workers in covered employment earned \$3000 or more in taxable wages, while in 1944 the percentage was 15.4.¹¹ If only those who had earnings in all four quarters of 1944 are considered, then 16 percent received less than \$1000; 37.7 percent received from \$1000 to \$1999; 26.6 percent received from \$2000 to \$2999; and 24.7 percent received \$3000 or more.¹² More than a third, 36.2 percent, of the men were in the top bracket, but only 2.4 percent of the women.

INSURED STATUS

It will be recalled that only persons who are fully or currently insured and their dependents are entitled to benefits, and that widows and parents of persons only currently insured receive limited benefits or none at all. Not all of those covered by the system can meet one or both of those conditions.

Total Insured. Table 9 shows the estimated numbers in millions who at the beginning of the specified years were either fully or currently insured or both.

There has always been a substantial proportion of workers with wage credits who do not have insured status because they do not have the necessary quarters of coverage. Every year there are millions of new entrants, and millions of workers, especially women, do not stay in covered employment long enough to acquire an insured status. At the beginning of 1940, approximately 56.4 percent of all workers with wage credits, a total of 22.9 million, were either

¹¹ *Ibid.*, May 1947, p. 26, Table 1.

¹² *Ibid.*, July 1947, p. 19, Table 13.

fully or currently insured. The percentage then declined steadily until it reached 51.7 at the beginning of 1944, the decline being accounted for by marked increases in new entrants, especially in 1941-1943, and withdrawals of insured persons into military service. Thereafter the percentage increased, reaching 55.0 in 1945, and fell very slightly below that figure in the two years following. The marked increase in 1945 resulted partly from the return to covered employment of millions of demobilized servicemen who were already insured, and partly from a decline in the employment of women.

TABLE 9. Federal Old-Age and Survivors Insurance: Estimated Number of Living Persons Fully or Currently Insured, by Year, 1940-1952¹³
(In Millions)

Beginning of Calendar Year	Total Insured	Fully Insured	Currently Insured Only	Permanently Insured
1940	22.9	22.9	.	0.6
1941	24.9	24.2	0.7	1.1
1942	27.5	25.8	1.7	1.4
1943	31.2	28.1	3.1	1.8
1944	34.9	29.9	5.0	2.2
1945	38.7	31.8	6.8	2.7
1946	40.3	33.8	7.0	3.3
1947	41.8	35.4	6.4	8.6
1948	43.4	37.3	6.1	11.6
1949	44.8	38.9	5.9	13.2
1950	45.7	40.1	5.6	14.9
1951	59.6	59.6	.	20.9
1952	62.3	62.3	.	22.6

Fully Insured. Fully insured status is more difficult to acquire than is currently insured status, but an overwhelming proportion of those having insured status are fully insured. In the early days of the system, nearly all who had insured status were fully insured, 97.2 percent at the beginning of 1941. Older people could easily acquire the minimum of six quarters of coverage, and the one-in-two requirement was not difficult to meet until a substantial amount of time elapsed. But the proportion declined steadily thereafter until it reached 82.2 at the beginning of 1945. Here again, mobilization of insured workers and new entrants show their effect. But "time elapsed" was also showing its effects. The proportion fully insured

¹³ *Social Security Yearbooks.*

increased again, reaching 83.9 in 1946 and 83.8 in 1947. At the beginning of 1952, a total of 62.3 million workers were fully insured, reflecting the "new start" which became effective in 1951.

Currently and Permanently Insured. Relatively few of the covered workers are only currently insured, but the marked increase in number since 1941 indicates that many of the new workers remained in covered employment long enough to become currently insured. In 1946, the requirement for becoming currently insured was liberalized to include earnings in the quarter of death, and as a result more will qualify. The decline as of the beginning of 1947 is attributed to a shift from currently to fully insured status and a decline in the number of new entrants into covered employment.

It has been estimated that on January 1, 1948, a total of 11.6 million workers were "permanently" insured, that is, they had accumulated either the required maximum of 40 quarters of coverage or one-half as many as the number of quarters elapsed since 1936 and before age 65. Of the 36.8 million fully insured on January 1, 1948, 32 percent were permanently insured. Most of them, 82.8 percent, were men. Approximately 7.7 million of these had 40 quarters of coverage. The others, born before 1892, had one quarter of coverage for every two quarters elapsing since 1936 and before age 65. Because, since the "new start," quarters of coverage acquired before 1951 are counted against "time elapsed," the number permanently insured has increased markedly, reaching 22.6 million in 1952.

TABLE 10. Federal Old-Age and Survivors Insurance: Number of Monthly Benefits and Lump-Sum Death Payments Awarded, by Type of Benefit and by Year, 1940-1946, 1952¹⁴

Type of Monthly Benefit	1940	1941	1942	1943	1944	1945	1946	1952
Total	254,984	269,286	258,116	262,865	318,949	462,463	547,150	1,052,303
Primary	132,335	114,660	99,622	89,070	110,097	185,174	258,980	531,206
Wife's	34,555	36,213	33,250	31,916	40,349	63,068	88,515	177,707
Child's	59,382	75,619	77,384	85,619	99,676	127,514	114,875	183,345
Widow's	4,600	11,010	14,774	19,576	24,759	29,844	38,823	92,302
Mother's	23,260	30,502	31,820	35,420	46,649	55,108	44,190	64,875
Parent's	852	1,272	1,266	1,264	1,419	1,755	1,767	3,868
Lump-sum death payments	75,095	117,303	134,991	163,011	205,177	247,012	250,600	304,863

BENEFITS

The heart of any social insurance system is naturally enough the benefit pattern. The Social Security Act of 1935 established a retire-

¹⁴ *Social Security Bulletins*.

ment plan which provided only one benefit, payable to insured persons who qualified. But amendments made in 1939 established the existing comprehensive system which provides benefits to dependents and survivors as well.

Benefits Awarded and in Force. Benefit payments were first made in 1940. Table 10, page 112, shows the number of awards made by types for the years 1940-1952. At the end of 1952, a grand total of 7,576,485 monthly benefits had been awarded, beginning with 254,984 in 1940 and increasing to 1,052,303 in 1952. The total awarded annually showed little change until 1944. The number of primary and wife's benefits awarded declined in 1942 and 1943 because many older persons continued to work, for patriotic and financial reasons, but with employment for older persons declining in 1944 and subsequent years more of them received benefits, markedly so in 1945 and 1946. Each of the other benefits awarded except the parent's increased fairly steadily every year, with minor exceptions, and notably the widow's, which went up from 4600 for 1940 to 45,-284 for 1947. First awards to husbands and widowers, 3077 and 267 respectively, are included in the 1951 totals for the wife's and widow's benefits. Awards of the parent's benefit are insignificant in number, but the number awarded has increased since the conditions of eligibility were eased. Lump-sum benefits awarded also increased each year until 1947, reaching a total of 304,863 for the year 1952. All benefits will continue to increase until the system reaches maturity and becomes stabilized.

At any given time, the number of benefits in force is considerably greater than the number awarded that year, since it is a cumulative figure. Table 11, page 121, shows numbers of benefits on a "current-payment" status, which means actually being received, on different dates. Some benefits are in force, that is they have been awarded, but are not being received because the beneficiary is working in covered employment or for some other reason does not receive the monthly benefit. At the beginning of 1948, only 87.5 percent of the benefits in force were actually being paid.¹⁵

At the end of the first year's operations, 222,448 monthly benefits were being received. The plan was just getting under way. Almost twice as many beneficiaries were cashing benefit checks at the end of 1941. War employment had a marked effect the next two years,

¹⁵ *Social Security Bulletin*, March 1948, p. 25. *Social Security Yearbook*, 1945, p. 47 gives data by years and types of benefits for 1945.

each year the number increasing only about 150,000 over the preceding year. Declining employment opportunities then increased the number appreciably, and by December 31, 1952, a total of 5,025,549 beneficiaries, or approximately twenty times as many as in 1940, were in a current-payment status.

TABLE 11. Federal Old-Age and Survivors Insurance: Number of Monthly Benefits on a Current-Payment Status on December 31, by Type and Year, 1940-1946, 1952¹⁶

Type of Benefit	1940	1941	1942	1943	1944	1945	1946	1952
Total, all types	222,488	433,722	598,342	747,816	954,881	1,288,107	1,642,299	5,025,549
Primary	112,331	199,966	260,129	306,161	378,471	518,234	701,705	2,843,932
Wife's	29,749	57,060	76,634	92,174	115,636	159,168	215,984	737,859
Child's	54,648	117,410	172,505	229,230	298,108	390,134	461,756	938,751
Widow's	4,437	14,963	28,631	46,133	67,806	93,781	127,046	454,563
Mother's	20,499	42,339	57,435	70,171	89,927	120,581	128,410	228,984
Parent's	824	1,984	3,008	3,947	4,933	6,209	7,398	21,460

A substantial percentage of the benefits in force are withheld for one reason or another. As of December 31, 1947, a total of 281,304 benefits, amounting to slightly more than \$6 million monthly, were being withheld.¹⁷ Employment of the beneficiary was the reason for withholding the benefit in almost 82 percent of the cases, and employment of the primary beneficiary on whose wages a dependent or survivor benefit was based was the reason in an additional 15 percent. Roughly one in three of the mother's benefits in force was being withheld because the mother was working in covered employment.

The proportion of each type of benefit withheld to all benefits of that type in force on December 31, 1947, was as follows:

Primary	18.1
Wife's	14.5
Child's	5.9
Widow's	1.7
Mother's	35.2
Parent's	1.1

There have been marked changes in the proportions which each of the various benefits bears to the total monthly awarded. These are shown in Table 12, page 115.

Primary benefits constituted a steadily declining proportion of

¹⁶ *Social Security Yearbooks*.

¹⁷ *Social Security Bulletin*, March 1948, p. 25

the total through 1944, going from 50.49 to 39.63, largely because older persons continued in employment during the critical war years. As older people left war industry, the proportion began to increase, reaching 52.03 percent of the total at the end of 1951.

TABLE 12. Federal Old-Age and Survivors Insurance: Percentage Which Monthly Benefits and Lump-Sum Payments Bear to Total Benefits Awarded, at End of Year, 1940-1946, 1951

Type of Benefit	1940	1941	1942	1943	1944	1945	1946	1951
Total*	100 00	100 00	100 00	100 00	100 00	100 00	100.00	100 00
Primary	50 49	46 10	43 47	40 94	39 63	40 23	42 73	52 03
Wife's	13 37	13 16	12 81	12 33	12 11	12 36	13 15	14 77
Child's	24 56	27 07	28 83	30 65	31 22	30 29	28 12	19 33
Widow's	2 00	3 45	4 79	6 17	7 10	7 28	7 73	8 78
Mother's	9 21	9 76	9.60	9 38	9 42	9 36	7 82	4 65
Parent's	0 37	0 46	0 50	0 53	0 52	0 48	0 45	0 44
Lump-sum death payments ^b	29 45	43 56	52 30	62 01	64 33	53 41	45 82	32.24

* Does not include number of lump-sum death payments

^b Ratio of lump-sum death payments to total monthly benefits awarded in year.

The number receiving primary benefits, i.e., in a current-payment status, is much smaller than the number who are 65 and fully insured and therefore "eligible," or the number of those eligible who have filed applications and are therefore "entitled" to the benefit. At the end of 1945, the number eligible for primary benefits was 1,425,000, of whom 43 percent were entitled to the benefit. But only 36 percent of those eligible were actually receiving the benefit, which was a substantial increase from the 29 percent in 1941. At the beginning of 1952, the number of persons eligible for primary benefits was 3,350,000; the number receiving them was 2,278,000, or 68 percent, an appreciable increase over the preceding year.¹⁸

The wife's benefit declined from 13.37 percent of the total in 1940 to 12.11 percent in 1944, and then began to move upward, reaching 13.15 at the end of 1946. Here again, defense and war employment by eligible males caused the decline. Postwar retirements resulted in a reversal of the trend. The gradual maturing of the system is also a factor, as it is for the primary and widow's benefits, but the effect of this was obscured by war conditions. The widow's benefit shows steadily increasing percentages through 1946. The benefit for mothers shows small erratic fluctuations until 1946, when substantial declines were registered. There was an actual decline of approxi-

¹⁸ *Ibid.*, September 1952, p. 34

mately 11,000 in the mother's benefits awarded in 1946. Reduced death rates in military service account in part for the decline.

The child's benefit also increased percentage-wise through 1944 and then declined. Here also there was an absolute decrease, of 12,639 in 1946. Parent's benefits increased substantially in percentage after the first year's operations, but leveled off until a decline set in, in 1945, which was only temporarily reversed in 1947, when eligibility conditions were eased. They constitute an insignificant proportion of the total.

The ratio of lump-sum death payments to total monthly benefits awarded steadily increased through 1944, partly because there was an increase in the overall mortality rate, from 5.2 per 1000 insured workers in 1940 to 7.1 per 1000 in 1944, occasioned by war deaths, partly because other benefits increased more slowly, and partly because of greater public awareness of benefit rights. The decline subsequent to 1944 reflects declining death rates among the insured and also relatively large increases in monthly benefits awarded.

In nearly all of these movements, the rate of movement up and down, except for the transitional year of 1946, is declining, which suggests that the process of stabilization has probably set in.

Size of Benefits. The number of benefits shows how many different persons enjoy some protection under the system. But the size of the monthly payment received indicates how far the system is succeeding in meeting the basic needs of its beneficiaries. Table 13 shows average monthly benefits by types and for specified periods. Although these are "average" and not "median" benefits, it is substantially true that half of the beneficiaries get more and half get less than the averages shown here.

TABLE 13. Federal Old-Age and Survivors Insurance: Average Size of Monthly Benefits in Force, by Type, as of Specified Dates ¹⁹

Type of Benefit	In Force as of End of				
	Jan.-Dec. 1940	Dec. 1942	Dec. 1944	Dec. 1946	Dec. 1952
Primary	\$22.71	\$22.96	\$23.58	\$24.63	\$49.25
Wife's	12.15	12.22	12.52	13.00	26.01
Child's	12.20	12.20	12.36	12.55	31.30
Widow's	20.36	20.17	20.16	20.20	40.67
Mother's	19.60	19.55	19.81	20.07	36.13
Parent's	13.09	13.04	13.07	13.14	41.33

¹⁹ *Social Security Bulletin*

The average primary benefit in force, which is the highest of them all, was only \$24.63 at the end of 1946 and had increased but slightly in seven years of operation. The explanation for this is simple enough. Benefits are based on wages received. Wages before the war were low. Workers who retired on benefits before the war continue on the rolls and their benefits are not increased. Wartime wage increases spread over the prewar years did not substantially increase the average monthly wage of workers recently retired. Most of the increase in wages yielded only 10 percent in benefits, and increases above \$3000 yielded nothing whatsoever.

The effect on amount of monthly benefits of the 1950 amendments, which made possible higher average monthly wages and provided more liberal formulas, is shown in Table 13. Comparison of the amounts being paid in December 1952 with those for December 1946, the latter being only slightly lower than those reported for December 1949, shows the extent of the increase.

The average monthly retirement benefit being paid in December of 1951 was \$42.14, as compared with an average of \$26 for December 1949, an increase of nearly 75 percent. On the average, retired persons 75 and older received higher benefits than those under 75. In 1952, the formula was again changed so as to increase the benefit by approximately \$5 monthly. The average primary benefit being paid to retired persons at the end of 1952 was \$49.25, somewhat more than half the statutory maximum of \$85.

The child's benefit of \$31.30 shown for December 1952 is the average paid to children of deceased persons. It will be recalled that when there is only one child of a deceased insured, the benefit is equal to three-fourths of the primary benefit amount; and when there are two or more it is one-half the primary benefit amount plus one-fourth divided by the number of children. This liberalized formula, together with the increase in the primary benefit amount, accounts for the markedly greater benefit paid to these children. The average monthly amount paid to children of retired persons, whose rate is 50 percent of the primary benefit amount, was only \$14.67 for December of 1952. There were 74,688 children of retired persons on the rolls, as compared with 864,063 children of deceased persons. An even greater increase was made in the parent's benefit, which is now three-fourths of the primary benefit amount.

The wife's benefit has increased greatly. But the rate at which it has grown was only slightly more than half that of the growth in the

primary benefit. This suggests that during the defense and war period, married persons were less prone than others to move into areas paying higher wages.

Most benefits, it will be noted, showed very little change until 1951. This was to be expected, for the insured persons on whose wages the benefits were based either died before large war-industry earnings were available or, being heads of families, tended to remain in their old jobs.

Family Benefits. The purpose of the wife's and survivor benefits is to make it possible for retired couples and widows with dependent children to live as families. Some data on combined benefits are available. The figures are national averages and for average families. There are important variations as between different regions, and as between different sized families.

Average combined benefits are low. Approximately 70 percent of total benefits go to families or groups, mostly to husbands and wives or to mothers and children. The benefit income of any family group thus depends upon how many benefits it receives and their amounts. The following figures, as of the end of 1952, show average combined family benefits.²⁰

Primary and wife	\$ 81.60
Worker and 1 child	74.20
Worker and 2 or more children	79.30
Widowed mother and 1 child	87.50
Widowed mother and 2 children	106.00
Widowed mother and 3 or more children	101.30
Two children	59.90
Three children	85.60
Four or more children	89.30
Two aged parents	80.40

The scale of benefits was raised appreciably in 1950 and again in 1954, and those increases were sorely needed. Even so, no one would seriously contend that they are now adequate for the needs of those families. Yet it must be remembered that were it not for this system of benefits, most of the families concerned would have even less and many would be receiving some charity or more than they are now receiving. Furthermore, it was never intended that this system provide the entire income needed by retired persons and survivors.

²⁰ *Social Security Bulletin*, September 1953, p. 41.

Other Income. The Federal Old-Age and Survivors Insurance system was designed to provide a basic minimum cash income to its beneficiaries. Its benefit amounts do no more than that, and supplementary income is needed by most beneficiaries. Until recently very little was known about the total money income received by beneficiaries of the system, and information on the subject is still scanty. A recent sample survey on a national scale of beneficiaries who received payments in all twelve months of the survey year throws some light on incomes.²¹

TABLE 14. Percent of Beneficiary Groups with Specified Amounts of Annual Money Income, National Beneficiary Survey, 1951

Type of Beneficiary Group	Percent with Total Annual Money Income of		
	Less Than \$600 per Person	\$900 or More per Person	\$1200 or More per Person
All groups combined	37	36	20
1-person groups:			
Old-age beneficiary:			
Nonmarried men	27	41	25
Nonmarried women	39	33	17
Aged-widow beneficiary	50	29	15
2-person groups:			
Married men:			
Wife entitled	39	32	15
Wife not entitled	40	37	22
Married women, no husband's benefit	24	50	36

It is clear from the data in Table 14 that many old-age beneficiaries have small total annual cash incomes. Including their old-age insurance benefits, more than one-third of those in the sample surveyed had less than \$600 for the entire year, and only slightly more than one-third had \$900 or more. Only 20 percent had \$1200 or more. The median total income for men primary beneficiaries was \$1137, for women \$830, and for aged widows \$609. Married men and women whose spouses were not also entitled to a benefit had the largest total cash incomes.

²¹ *Ibid.*, August 1952, pp. 3-6; June 1953, pp. 11-18.

For some of these beneficiaries, approximately 15.5 percent, the monthly old-age insurance check was their only cash income, and about as many more had less than \$150 additional income for the year. Approximately 50 percent of the aged widows had nothing but their check or had less than \$150. For those having more than their benefits, the "other income" median for men was \$609, for women \$497, and for aged widows \$322. Fewer than one-half of the beneficiaries, roughly 46 percent, had any permanent retirement income other than their old-age insurance, such as employer, union, or veterans' pensions, private annuities, and interest and dividends. About one-fourth of the men, one-fifth of the women, and one-eighth of the aged widows earned some money in covered and uncovered employment, but in most cases the amounts were small.

It should be added that a substantial proportion of them had other sources of support. Nearly half of the beneficiaries, 46 percent, owned their own homes, and this was true of nearly two-thirds of the married beneficiaries, although some of the homes were mortgaged. Some of the single or widowed lived with relatives. Even so, some of them found it necessary at times to seek public assistance to supplement their other resources. It should be noted that benefit rates were increased slightly after the survey was made and that the maximum amount that can be earned without losing the benefit was also increased.

Benefits to Survivors of Deceased World War II Veterans. It will be recalled that in 1946 the Congress made provision for paying benefits to the survivors of veterans of World War II. The first of these payments were made in September of 1946. During the last four months of that year, monthly benefits were paid to 1770 widows, orphans, and parents of 740 deceased veterans in accordance with the provisions of the 1946 Act. These were "initial entitlements," and did not include some awards originally made in accordance with the regular provisions of the Old-Age and Survivors Insurance plan and which were later recomputed under the veterans' provisions in order to allow higher benefits.²²

Of these 1770 beneficiaries, 508 were widows, 1181 were children, and 81 were parents. The average primary benefit amount was \$32.67. Widows with one or more children received an average monthly benefit amount of \$49.30, families with one or more chil-

²² *Social Security Yearbook, 1946*, p. 19, Table 29

dren received \$40.06 where the veterans were married and \$28.77 where the veterans were single, widowed, divorced, or of unknown marital status, and parents, one or more, received \$19.11.

Benefits were not payable to 1020 survivors of 438 of these veterans under the regular system, and they would therefore not have been paid except for the amendment. As would be expected, the average primary benefit amount of these veterans was slightly lower, \$32.07, than that of those who were also insured in the regular system, \$33.54. In the cases of veterans regularly insured, the average primary benefit amount was increased \$10.28 by the provisions of the veterans' act.

Lump-sum funeral benefits were paid to the survivors of 2854 deceased veterans under this program, and the average amount was \$192.39. These benefits would not have been paid in 1905 cases had it not been for this law. For those who were regularly insured, the average lump-sum payment was increased by \$12.35 as a result of the special act.

Altogether, a total of \$202,700 was certified for payment of monthly benefits and \$461,700 for lump-sum payments in the last four months of 1946. The effects of this special legislation will continue to be felt for many years.

Termination of Benefits. Every year thousands of benefits are terminated in accordance with the provisions of the law. In 1946, for example, there was a total of 147,949 terminations, involving monthly payments amounting to \$2,709,748.²³ Of these, 62,304, or 42.1 percent of the total, were terminated because of the beneficiary's death, and 15,507, or 10.5 percent, because of a husband's death. The wife's benefit, it will be recalled, is terminated when her husband dies and she then becomes eligible for a widow's benefit. Marriage, remarriage, divorce, or adoption of the beneficiary accounted for termination in 18,249, or 12.3 percent, of the cases. A total of 37,611 child beneficiaries attained age 18 and the termination of their benefits accounted for 25.4 percent of the cases. There were 12,977 cases, or 8.8 percent of the total, where the last entitled child attained 18 years and the widow's current benefit had to be terminated. In only 438 cases were benefits terminated because the beneficiary became entitled to another equal or larger benefit. A total of 245 benefits were terminated for other reasons.

²³ *Ibid.*, p. 16.

ADMINISTRATION

The original Social Security Act of 1935 established the Social Security Board, consisting of three members appointed by the President, to administer the various programs undertaken. By far the largest of these programs was the Old-Age and Survivors Insurance system. A Bureau of Old-Age and Survivors Insurance was established by the Board.

President Truman's Reorganization Plan No. 2, which became effective July 16, 1946, abolished the three-man Social Security Board and placed all of its functions, together with many others, in a Federal Security Agency. Within the Federal Security Agency there is the Social Security Administration, headed by a Commissioner of Social Security. That Administration exercises all of the functions formerly exercised by the Social Security Board. The Social Security Administration is now a part of the Department of Health, Education, and Welfare.

The Bureau. The Bureau of Old-Age and Survivors Insurance, which was continued in the Social Security Administration, administers Old-Age and Survivors Insurance. Tax returns collected by the Bureau of Internal Revenue from employers and self-employed persons are transmitted to the Bureau. Wage and self-employment income items reported are credited to the individual accounts in the Baltimore office, and in the fiscal year 1951-1952 more than 225 million of them were posted to some 85 million individual accounts. The Bureau through its field offices passes on claims for benefits, determines the amounts due, and makes proper certifications to the Secretary of the Treasury, who issues the individual checks. It investigates and makes original determinations on appeals from dissatisfied claimants. And it performs the simple police function of investigating violations of the Act by claimants. There is an Appeals Council, to be described below, which is altogether independent of the Bureau and reports directly to the Social Security Administrator.

A Director heads the Bureau. There are six area offices, 570 field offices, 90 official stations, and approximately 2800 itinerant stations to serve claimants and beneficiaries. The field organization has steadily grown in size, while the departmental, i.e., employees in

Washington, has for years been diminishing in size. The fiscal year 1945-1946 was the first in which there were more employees in the field than in the departmental organization.

The total cost of administering the system, including the cost incurred by the Bureau of Internal Revenue in collecting contributions and the cost to the Treasury Department of administering the Trust fund, has steadily increased as coverage has been expanded, new benefits added, and changes in eligibility requirements and benefit formulas made. For the fiscal year ending in 1953 it amounted to \$89.4 million. This was approximately 2.2 percent of the \$4.1 billion of contributions and transfer income for that year. The ratio of administrative costs to receipts will tend to decline as contribution rates go up. Administrative expenses amounted to approximately 3.3 percent of the \$2.6 billion paid out in benefits. Recent changes in coverage, benefit amounts, and conditions of eligibility will increase costs still more. Although costs have been increasing, they do not appear to be excessive.

Administrative expenses were paid by the Federal government until the system was well under way. Beginning with the fiscal year 1939-1940 they have been paid out of the system's own receipts.

Appeals. The original law did not require that dissatisfied claimants be given a hearing, but in 1939 the Act was amended to provide that right, and appeals procedures and machinery have been established.²⁴ During the fiscal year 1946-1947, requests for hearings were filed in 1658 cases, hearings were completed in 1519 cases, and referees disposed of 1500 cases.

From 6 to 9 percent of all claims filed are disallowed, and in no year through 1945 were requests for hearings on disallowed claims in excess of 3 percent. The high of 3 percent was reached in 1941 and it then declined to 1.7 percent in 1945. During this same period of years, the percentage of total claims disallowed rose from 6.3 in 1941 to 8.0 in 1945. Benefit adjudications have been almost universally acceptable, the number of claimants disagreeing with them being "not more than 1 percent in any year and only one-seventh of 1 percent in 1944-45." In two-thirds of the cases heard, no change is made in initial determinations.

Most of the appeals, approximately three-fourths, involve dis-

²⁴ Ernest R. Burton, "The Appeals System in Old-Age and Survivors Insurance," *Social Security Bulletin*, July 1946, pp. 4-10.

allowed claims. A few are made because the claimant believes that the size of his monthly benefit or lump-sum award is too small. Normally not many appeals result from suspension of benefit payments, but during the war years the number was disproportionately high, and in 1944-1945 these appeals amounted to 26 percent of the total, which was twice as high as in any previous year. Even so, suspension appeals in 1945 were taken in less than one-fourth of 1 percent of the suspensions made.

Appeals are first considered in hearings held by hearing referees. There are 12 regional hearing referees, with a consulting referee to give them legal advice, and they have technical and clerical assistants. Hearings are held locally in such places as post offices, courtrooms, city halls or other public buildings, and sometimes in the residences of appellants. Testimony taken is recorded by a reporter who accompanies the referee. Cases are usually disposed of within six weeks after they are initiated.

Appeal from the hearing referee's decision may be taken to the Appeals Council, a three-member body which sits in Washington, D.C. The Council is independent of the Bureau which administers the Old-Age and Survivors Insurance program and is directly responsible to the Social Security Commissioner. Few cases are appealed to the Council, and those appeals are generally disposed of within four weeks.

There is provision for judicial review of decisions made by the Appeals Council. Civil actions may be initiated in United States district courts. A total of 42 such actions, involving nearly all possible issues, were begun between July 1, 1940, and through December 31, 1945, involving claims of 70 individuals. Final court decisions were rendered in 74 cases through June 30, 1950, and in all but 23 the decision of the Appeals Council was upheld, and some of those cases involved fine legal points on which opinion was divided. As of June 30, 1950, there were 27 civil actions pending in the courts. In 12 of the 16 cases decided during the fiscal year, the Administration was upheld.

FINANCIAL OPERATIONS

Money to pay benefits and operating costs is secured from payroll taxes on covered wages, employers and employees paying equal

rates. Table 15 summarizes the financial aspects of the program.

Income. Receipts, including taxes, interest, and penalties, from the beginning of 1937 through June 1953 amounted to a grand total of about \$26 billion. The annual income is now running at approximately \$4.5 billion. The marked increase in revenue which occurred in 1950-1951 reflects primarily the higher tax rate which became effective then, but also the higher maximum taxable wage established and the broadened coverage. Further marked increases will occur if the tax rate is raised as was planned, and moderate increases will occur with still more expanded coverage.

TABLE 15. Status of Old-Age and Survivors Insurance Trust Fund,
by Fiscal Year, 1936-1953 ²⁵
(In Thousands)

Fiscal Year	Receipts			Expenditures		Assets at End of Period
	Total	Taxes	Interest Received ^a	Benefits	Administrative Expenses ^b	
1936-1937	\$ 267,262	\$ 265,000	\$ 2,262	\$ 27	.. .	\$ 267,235
1937-1938	402,412	387,000	15,412	5,404	.....	777,243
1938-1939	529,951	503,000	26,951	13,892	.. .	1,180,302
1939-1940	592,489	550,000	42,489	15,805	\$12,288	1,744,698
1940-1941	744,099	688,141	55,958	64,342	26,840	2,397,615
1941-1942	966,626	895,619	71,007	110,281	26,766	3,227,194
1942-1943	1,217,898	1,130,495	87,403	149,304	27,492	4,268,296
1943-1944	1,395,299	1,292,122	103,177	184,597	32,607	5,446,391
1944-1945	1,433,773	1,309,919	123,854	239,834	26,950	6,613,381
1945-1946	1,385,984	1,238,218	147,766	320,510	37,427	7,641,428
1946-1947	1,622,958	1,459,867	163,466	425,582	40,788	8,798,390
1947-1948	1,807,424	1,616,862	190,562	511,676	47,457	10,046,681
1948-1949	1,923,769	1,693,575	230,194	607,036	53,465	11,309,949
1949-1950	2,366,770	2,109,992	256,778	727,266	56,841	12,892,612
1950-1951	3,411,490	3,124,098	287,392	1,498,088	70,447	14,735,567
1951-1952	3,931,496	3,597,982	333,514	1,982,377	84,649	16,600,036
1952-1953	4,483,242	4,096,602	386,640	2,627,492	89,429	18,366,356

^a Interest on investments held is credited annually in June; on investments redeemed, in month of redemption.

^b Bookkeeping adjustments have been made for some years and the figures do not reflect actual cash outlays in respective years

Expenditures. The amount paid out in benefits, which totaled \$9.5 billion by the end of June 1953, has increased steadily each

²⁵ *Social Security Bulletins.*

year as more persons become eligible for them. This slow increase is characteristic of any system during the period in which it is maturing, since in the early years the number of beneficiaries is small. Monthly benefits to dependents and survivors became payable in 1940-1941, and the higher benefits established by the "new start" in 1950 account for the marked increase beginning in 1950-1951. The total for 1952-1953 reflects the increased number of beneficiaries who had not been covered before coverage was extended, and to a smaller extent the slight increase in benefit amounts. Benefit payments will continue to increase for many years, until the system matures.

Administrative expenses have been low. The increase in 1940-1941 resulted when the law was changed from a simple retirement system to one providing benefits to dependents and survivors as well. The marked increase beginning in 1950-1951 occurred because coverage was appreciably extended. For 1952-1953, administrative expenses amounted to 3.63 percent of benefits paid.

The Reserve. There has been a steady growth in the size of the reserve. Beginning with a little more than a quarter of a billion in 1936-1937, it slightly exceeded \$18 billion at the end of the fiscal year 1952-1953. It would have been considerably larger if Congress had permitted increases in the contribution rate to 3 percent each by 1949, as originally planned. But Congress "froze" the rate at 1 percent on each until 1951, when it was increased to 1½ percent. At first, fear of the effect of higher taxes on the progress of economic recovery, then fear of the possible adverse effects of a huge reserve on politicians as well as on the economy, and more recently a strong desire to shift to a "pay-as-you-go" system, with annual receipts and expenditures balancing, have all played a part in holding down the rate, and consequently the reserve.

A House Ways and Means technical staff reported in January 1946 as its "concluding suggestion" that every 10 years the contribution rate be raised one-half of 1 percent for each until it reached a maximum of 3 percent in 1977. It was noted that this progression might not be adequate, and the staff suggested that any schedule adopted "should contemplate support from general revenues when benefits for a particular year exceed the taxes and interest on reserve for that year. . . ." ²⁶ The Congress did not adopt that sug-

²⁶ Quoted in Social Security Board's *Annual Report for 1946*, p. 450.

gestion, although for a brief period it did pledge itself to meet the obligation, as a "sop" perhaps to those who believed that freezing the rate at 1 percent jeopardized the actuarial soundness of the system.

Should we adopt the pay-as-you-go plan, the existing reserve could be maintained, and it might even be increased slightly. That reserve would provide a balancing income during years of business depression or recession. It could, however, be eliminated altogether if the Congress advanced funds on loan during years when expenditures exceeded income.

The law provides that money appropriated may be invested in United States interest-bearing obligations or in obligations of which the payment of both the principal and interest is guaranteed by the Federal government. The money may be invested in any U.S. obligations regularly offered to the public, or the government may make a special offering for the sole purpose of investing Old-Age funds, provided the purchase of regular issues is "not in the public interest." However, special offerings will bear a rate of interest equal to one-eighth of 1 percent next lower than the computed average rate on all outstanding U.S. interest-bearing obligations. The computed average interest rate received declined steadily from 3.000 percent in the fiscal years 1937-1939 to 2.046 at the end of the fiscal year ending 1946, and the decline continued through May 1947, after which there was a slight increase. The computed average rate on the interest-bearing public debt was lower until 1946, and has been higher since, amounting to 2.137 as compared with 2.082 in November 1947.

Until May 1943, it was the policy to invest all money appropriated and to pay benefits out of money secured by redeeming obligations already possessed. The system was thus buying and selling at the same time. Until February 1942, only special Treasury obligations issued exclusively for that purpose were purchased. But in that month some regular 2.5 percent Treasury issues were bought, for it was found that the rate on the special issue would have been only 2.375 percent. The policy of buying regular or special issues, whichever yields the higher rate, has been continued.

In May 1943, the policy was instituted of using currently appropriated funds to meet current outlays and to sell obligations already held only when current appropriations fall short of outlays. The

computed average rate of interest on all outstanding U.S. obligations had fallen so low that special issues were yielding less than regular issues. It was 2.195 on July 31, 1944, as compared with 2.260 a year earlier. It was profitable to hold higher rate obligations purchased previously. In December 1942, some 2 percent obligations had been purchased—the lowest rate to that date. Quite a few short-term issues, bearing 1½ percent interest, had been bought, the first one in June 1944. On June 30, 1946, about \$7.6 billion was invested in Federal securities at an average interest rate of 2.05.²⁷

SOCIAL SECURITY NUMBERS

The number of persons covered by any comprehensive social insurance system is so great that similarity of names is a source of serious confusion and error. There are approximately 294,000 Smiths, 227,000 Johnsons, 165,000 Browns, 156,000 Williamses, and tens of thousands of others with identical surnames and in many cases with identical given names as well. Fingerprints could be used successfully to distinguish between individuals, but because they have for so long been associated in the public mind with criminals they have not been required in social insurance systems in this country.

Account numbers, known as Social Security Numbers, are used instead. Each worker in employment covered by the Old-Age and Survivors Insurance Act must apply for and will receive a separate and distinct number, which is based on the following arrangement of digits: 000-00-0000. The first three, known as the "area numbers," represent the state or possession in which the number was issued, and there could be 999 areas. New York state, for example, has been assigned the area numbers 050 through 134, Ohio 268 through 302, Kansas 509 through 515, Utah 528 through 529, and California 545 through 573. The next two digits, known as "group numbers," constitute numerical indications of the ten-thousand series in which the serial number, the last four digits, has been assigned. Ten groups were used at first, each one having 10,000 individual account numbers. The last four digits are serial numbers within the group, indicating the order in which the account was established in that group. The employee's application for an account number contains

²⁷ *Annual Report of the Federal Security Agency, Social Security Board*, 1946, p. 449.

information useful for identification purposes, such as age, birthday, father's first name, mother's maiden name, sex, and color. The capacity of this arrangement is about 1 billion account numbers.

By the end of 1952, a total of 106,816,000 social security numbers had been issued. It was estimated that by that date 85 million living persons, equal to 78 percent of the total population 14 years of age and over, had numbers. It was also estimated that 70 percent of the male and 43 percent of the female population above 14 years of age had numbers. These figures are in striking contrast to those for 1940. At the end of that year, 54,225,212, equal to 48.7 percent of the population 14 years of age and over, had numbers, 66.6 percent of the males and 30.9 percent of the females. The percentage of the total population having numbers has increased every year, but very much more rapidly for women than for men.

Employer account numbers are based on the following arrangement of digits: 00-0000000. The first two show the internal revenue district in which the employer is located, and there are now 64 of these. The other digits are simply serial numbers. Since the records of employers are filed alphabetically, only every tenth serial number is used at present. Employers' applications for account numbers contain, among other things, descriptions of the principal products or services produced, thus making possible classifications by types of activity. The capacity of this arrangement is one less than 10 million in each revenue district. Only about 4.5 million employers are covered by the system.

Social security numbers are issued primarily in connection with the Federal Old-Age and Survivors Insurance system, but they are also required in the Railroad Retirement and Railroad Unemployment Insurance systems, and are used in state unemployment compensation systems as well. The 700-area series has been reserved for the Railroad Retirement Board, which administers the two railroad systems. The Railroad Retirement Board issues numbers to employers and employees covered by the systems it administers. Numbers are interchangeable. A worker who, let us say, leaves employment covered by the Federal Old-Age and Survivors system and enters employment covered by the Railroad systems keeps his original social security number, and vice versa.

The Social Security Administration has a separate account for each covered worker. Employers must make quarterly returns in

which they must report the names, numbers, and amounts earned for each covered worker employed. The information on wages is "punched" on cards, and "posted" to the worker's individual account by machines. Were it not for this complicated and effective machinery, the task of keeping such detailed records would be excessively expensive. Wage records are kept in Baltimore.

CHAPTER SIX

THE RAILROAD RETIREMENT SYSTEM: PROVISIONS

A COMPREHENSIVE and fairly complex system of retirement and survivor annuities has been established by Congressional action for workers in the railroad industry. The development of that system is a significant chapter, not yet completed, in the history of American social insurance.

THE EARLY MOVEMENT

The system did not come "out of the blue." Long before it was established, railroads had voluntarily provided pensions for their employees. Later, after the Great Depression had led many roads to limit their systems, a struggle ensued to establish a system by law. A brief glimpse into the early movement will be worth while.

Voluntary Pensions. Railroads were the first industrial organizations in this country to establish pension plans for their employees. The very first is believed to be the one established by the American Railway Express Company in 1875. The Baltimore and Ohio Railroad, usually credited with being the first road to have one, established its plan in 1884. There was very little pension activity in the railroad industry during the remainder of the century, and the next plan was not adopted until 1900. But considerable progress was made in the first decade of the Twentieth century. By 1910, there were 18 or 19 pension plans in operation. The railroads concerned employed about 50 percent of the industry's workers, included no more than 30,000 miles of track, or less than 15 percent of the total, and had 4638 pensioners receiving an average of about \$170 per year, or \$3 a week, amounting to a total of about \$800,000 per year.

All of the earlier railway plans were of the noncontributory type.

A period of continuous service, usually 20 or 25 years, was a condition of eligibility, which meshed with the common maximum employment ages of 40 or 45. Retirement was commonly optional at age 65 and compulsory at 70. The amount of the pension was generally set at 1 percent of the average annual pay for the 10 preceding years times the number of years of service. Normally only service with the pensioning carrier was counted. The maximum pension was thus usually 25 percent of the pay during the preceding 10 years.

Administration of the plans was wholly by the railroad companies. Furthermore, contractual obligation to pay generally did not exist, and companies could modify, suspend, or cancel their plans at will. Pensions were treated as operating expenses and paid out of current revenues. Until 1928, the Interstate Commerce Commission did not permit carriers to charge pension payments to operating accounts until they had actually been paid out, which meant that reserves could not be set up. In December of 1928, the Commission authorized the formation of reserves where carriers had a definite contractual obligation to pay such pensions.¹

There were several common motives for establishing these retirement plans. One was the simple humanitarian motive of rewarding old and faithful employees. Another was to facilitate the removal of persons whose efficiency declined with age, especially in certain activities where considerable damage might result to life and property. Perhaps more important was the desire on the part of the railroads to attract and bind ambitious employees more securely to their jobs. Still another motive appears to have been to discourage strikes. Pensions were payable for "continuous" service, and a strike could be construed as a break in continuity.

The railroad unions did not seem to be particularly concerned, one way or the other, about the pension movement. The Big Four train service unions in 1891 jointly established and maintained a home for "worthy, aged and disabled, helpless and destitute railroad men who are no longer able to provide for themselves." Later, in 1927, the Conductors established one of their own. Late in 1919, the Big Four issued a declaration of "Grievances, Protests and Demands" in which they insisted on being "masters of themselves" and offered solutions to sundry world problems, but in which they said nothing at all about pensions.²

¹ *Monthly Labor Review*, October 1930, pp. 101-103.

² *Ibid.*, February 1920, pp. 33-41.

The pension movement in the railroad industry continued to grow. By 1932 there were 84 plans. They were all noncontributory and all but two were financed out of current revenues. Approximately 1.5 million workers were covered, there were 51,000 pensioners, and they received \$50.6 million. Compulsory retirement was usually at age 70, although earlier retirement was permitted in cases of disability. Minimum periods of service required for eligibility varied from 10 to 35 years. No change had been made in the method of computing the retirement allowance. A few of the plans provided benefits for survivors of officials with long tenure.

In 1937, there were about 50,000 employees drawing pensions, and about that many more had at one time or another been on the rolls since the beginning of the plans. By 1937 the annual cost was running about \$36 million a year, and more than \$400 million had been paid out since the movement began.

The Act of 1934. In 1934, the Congress enacted a railroad retirement law, the first compulsory retirement system for nongovernmental employees enacted in this country. Born of the depression, it paid lip service to the idea that the plan would promote operational efficiency and safety, but the primary purpose was to ease older men out of their jobs in order that unemployed younger men might have them. Declining employment and the seniority system had resulted in a disproportionately large number of older employees.

Coverage. The Act covered railroad, express, sleeping-car and other companies owned or controlled by one or more railroads which operated or serviced equipment used to transport passengers or property, not including street and interurban electric railways unless operated as part of a general railroad system. It did not include the "captive" coal mines owned by railroad companies. In addition to the employees of the above mentioned companies, the officers and official representatives of national standard railroad unions were included if they elected to be covered. The coverage extended not only to workers who were employees at the time the act became effective and to those subsequently employed, but also to those who had served within one year preceding the enactment of the law, a provision which was later to cause serious legal difficulties.

Benefits. Retirement annuities for those eligible at the time the law was enacted were to be based on the average monthly compensation earned during the years 1924-1931 inclusive, and for those

subsequently becoming eligible they were to be based on the average compensation for the full period of service. The specific amount in each case was to be determined by taking 2 percent of the first \$50 of the average monthly wage, 1.5 percent of the next \$100, and 1 percent of the next \$150. The sum of these three was to be multiplied by the number of years of service, but not exceeding 30 years. Thus the largest possible monthly annuity was \$120.

Normal retirement at age 65 was contemplated, and annuities became payable at that age. Retirement could be postponed from year to year by written agreement between carrier and worker, but was compulsory at age 70, although compulsory retirement was not to be applicable to railway officials until five years after the law became effective and not at all to employee representatives. Optional retirement before age 65 was permitted, but for each year under age 65 the amount of the annuity was to be reduced by 1/15th. But there was to be no reduction in the annuity if retirement was due to disability.

Death benefits were provided, payable in case death occurred either before or after retirement, and they consisted of the total amount paid in by the employee with 3 percent interest, less the amount of annuities received. In this way the worker was guaranteed a return of the amount he contributed, at 3 percent interest. If, when a worker retired, the commuted or capitalized value of his annuity amounted to less than \$300, it was to be paid to him in a lump sum.

Taxes. Funds for the payment of these annuities were to be secured from taxes levied on carriers and workers, the percentage to be adequate to meet all needs and to be determined "from time to time" by the Railroad Retirement Board, an agency created to administer the act. In other words, the plan did not contemplate the creation of a large "reserve." No provision was made for any Government contributions.

Rates levied on carriers were to be twice those on employees, and were not to be levied on that part of wages in excess of \$300 per month. Until further determination by the Board, the rates were to be 2 percent on employees and 4 percent on employers. The money was to be paid into a special fund in the Treasury of the United States. A Railroad Retirement Fund was established and the money received was to go to that fund to pay annuities, lump-sum payments, and administrative expenses, and this fund was to be managed by the Railroad Retirement Board. Thus a "pooled"

fund for the entire industry was established rather than a system of "employer reserves."

The Board was authorized to bring existing voluntary pension plans under the provisions of this act, and if the cost of the system was therefore greater than it would otherwise have been, the extra cost was to be borne by the railroads responsible for the original pensions. If agreement with the railroads on this matter was not possible, the law of 1934 was to be applied to those pensioners irrespective of conflicts and duplications. As an alternative, the Board was authorized to make the benefits of the law available to all former employees who had reached, or when they did reach, the age of 70, whether they were receiving voluntary pensions or not.

Administration. The Railroad Retirement Board mentioned above was created as an independent agency in the executive branch of the Government. It consisted of three members appointed by the President with the advice and consent of the Senate for terms of five years. One was chosen from a list of nominations submitted by railroad union representatives, one from a list submitted by carrier representatives, and the chairman who was not affiliated with either group. Salaries were set at \$10,000 annually.

Unconstitutionality of the Act of 1934. The Act of 1934 was challenged in the courts by the railroads. In the Supreme Court of the District of Columbia, the Act was declared unconstitutional, and from there it was taken to the United States Supreme Court, where the decision of the lower court was upheld.³ It was a split decision, five to four, the Chief Justice siding with the minority.

The Majority View. Mr. Justice Roberts delivered the majority opinion. First of all, the majority made its formal bow to the basic concepts that the Court could not inquire into the wisdom of an Act of Congress, that novelty did not indicate unconstitutionality, and that the Court must fairly construe the powers of Congress. It then launched into a penetrating criticism of the basic provisions of the Act. Every major provision regarding benefits was considered to be fundamentally wrong. The Court found the basic provisions of the Act so arbitrary and unreasonable that they contravened the due process clause of the Fifth Amendment. Some of the provisions were held clearly to take property without due process of law. And the

³ *Railroad Retirement Board v. Alton R. Co.*, 295 U. S. 330.

Court held that these basic provisions were so integral a part of the Act that they could not be separated from the remainder.

There is much to be said in favor of the criticisms of specific provisions made in the majority opinion. The Act was certainly most generous with other people's money, and the justice of some of that largess could rightfully be questioned. But the majority opinion went much further than to declare objectionable features unconstitutional. All parties agreed that the pertinent constitutional provision was the Commerce Clause "exercised in subjection to the due process of law found in the Fifth Amendment." The majority held that even if the law could survive the loss of the unconstitutional features, it still had a fatal defect. For "the act is not in purpose or effect a regulation of interstate commerce within the meaning of the Constitution." In short, the Congress simply did not have the power to enact a compulsory retirement system for interstate commerce. The Supreme Court of the District of Columbia had found some features unconstitutional, but it was of the opinion that the Congress had power to enact such a law.

The Minority View. The minority opinion was written by the Chief Justice and concurred in by Justices Brandeis, Stone, and Cardozo. That some of the principal features could be considered unconstitutional was admitted, although the minority was inclined to give Congress the benefit of the doubt on some of them and it disagreed with the majority on others. The provision making pensions payable to persons in railroad service within one year of the law's enactment seems to have been unanimously considered unconstitutional. The minority believed that the Court should have regard to the explicit provision of the Act as to severability. But the major fault found with the majority opinion was the ruling that denied Congress the right to pass any retirement legislation at all. That was an "unwarranted limitation upon the Commerce Clause of the Constitution."

The Act of 1935. The Supreme Court's decision invalidated the Act of 1934. But the Congress was not to be denied so easily, and proceeded to pass another act in 1935, to become effective on March 1, 1936.⁴ In some respects the new act was similar to that of 1934, but there were several important differences.

Differences from the 1934 Act. One extremely important differ-

⁴ *Public No. 399*, and also *Public No. 400*

ence was that the new retirement act was separated altogether from the provisions for raising funds, a procedure deliberately adopted to circumvent, if possible, the Supreme Court's declaration of unconstitutionality. The benefits provided in the new act were to be paid out of the general fund of the Treasury. An entirely separate act with no ostensible relation to the retirement act was passed levying the taxes which were expected to raise the necessary revenues, and the tax burden was divided equally between workers and carriers, 3.5 percent on each. The Railroad Retirement Board had no authority to function whatsoever with respect to the source of the funds.

There were other less fundamental differences in certain provisions. Optional joint-and-survivor annuities were provided, which were later included in the Act of 1937 and will be described below. Compulsory retirement at age 70 was no longer required. And there were some differences in the death benefit provisions and in the method of computing them. The Congress really made no great concessions to the Supreme Court in the matter of specific provisions of the retirement system, despite the Court's devastating criticism.

The Act in Court. Practically all of the employers affected by this act, together with a few employees of the Atlantic Coast Line, joined in another action in the District Court of the District of Columbia, claiming that the act was "arbitrary, capricious and whimsical" and that it deprived them of their property without due process of law.

The Court, speaking through Mr. Justice Bailey, made a gesture at trying to find some basis for the taxes levied other than as a part of a general retirement system, but of course it could not find any basis, and for the simple reason that there was none.⁵ Senator Wagner in a discussion of the bill had made it clear that the Federal government was not expected to pay any of the cost, and the general plan was clearly outlined in the retirement act.

Standing by itself, the tax act was held to be "so arbitrary and capricious as to cause it to fall before the due process clause of the Fifth Amendment." Taken in conjunction with the retirement system, the tax provisions made some sense. Each of the two was a "necessary part of one entire scheme." But since the system as a whole contained many of the features that had led the Supreme Court to declare a similar act unconstitutional, the Court found itself unable

⁵ *Alton R. Co. v. R. R. Board*, 16 Fed. Supp. 955.

to approve. The Railroad Retirement Board was therefore enjoined from taking any action to compel the carriers to provide information and records, and the Commissioner of Internal Revenue was enjoined from collecting the taxes.

The decision of the District Court apparently was not altogether clear about certain matters and it was clarified orally by Mr. Justice Bailey in a conference with Board officials a few days later.⁶ Mr. Justice Bailey announced that the import of his decision was to declare only the taxing act unconstitutional and not the retirement act. He refused to pass on the Board's power to certify annuities, and the Board interpreted this to mean that it could go ahead and pay the annuities provided. The money would come from the general revenue fund. Mr. Justice Bailey thought that the Federal government had a right "to work out a pension payment plan to retire employees and can collect contributions for that purpose from the employees." But until the case was finally determined by the Supreme Court, any money collected from employees must be held in a special account. The Board, he held, could examine employers' records in order to determine eligibility and benefit amounts, but at its own expense.

Annuity Payments Begin. On the basis of this oral statement and in utter disregard of the Supreme Court's views on the constitutional aspects of the matter, the Board proceeded with its plans and collected information. Employers were unwilling to cooperate in any way that might prejudice their position in litigation pending in higher courts. The decision had been appealed. The Board paid its first annuities to eligible workers on July 13, 1936, less than two weeks after the oral clarification. The Congress had appropriated about \$47 million for that purpose.

The legal outlook for the future was not too bright, since there was no reason to believe that the Supreme Court would change its mind on the subject. Congress had appropriated some money to pay annuities and expenses, and taxes on employers and employees could not be used. However, there was some reason for believing that the carriers were not opposed in principle to a compulsory retirement system and that they were willing to give financial support. The carriers did object to the lavish and even reckless manner in

⁶ *Monthly Labor Review*, August 1936, p. 329, *New York Times*, July 1, 1936, p. 19.

which it had been proposed to distribute money in the two preceding acts.

The Joint Conference. At the suggestion of President Franklin D. Roosevelt, made late in December of 1936, a Joint Conference on Railroad Retirement was held, which was attended by representatives of railroads and railroad unions. The Board assisted in discussions on technical aspects of the problems facing the Conference.

The object was to work out a mutually satisfactory system that would not have to run the gamut of the courts. A plan was devised which was later incorporated in the Act of 1937. Although it was a compromise, perhaps because it was, the new law was a marked improvement over the previous laws. The agreement was the basis for terminating the litigation pending on the law of 1935, and the carriers agreed not to challenge the constitutionality of an act incorporating the provisions of the agreement. The railway labor unions on their part agreed that they would never ask the Congress for any change in the retirement law that would depart from the principle of equal tax contributions from workers and carriers. But there was no specific agreement as to other changes that might be requested. The agreement was enacted into law in 1937.

THE PRESENT RETIREMENT ACT

The Act of 1937 represented the first instance in this country where labor and management cooperated to devise a social insurance plan made compulsory by law for the entire industry. It was called "the most unanimously approved legislation" to have come out of the House Committee on Interstate and Foreign Commerce, and "the finest example of industrial statesmanship in the history of America."⁷

The provisions of that act, as amended, will now be described. It should be noted that the Act of 1937 is in form amendatory of the 1935 act and that certain determinations as to annuities and death benefits made pursuant to the 1935 act are continued in effect. Those will be included in the description.

Coverage. The system is designed to apply to the railroad trans-

⁷ Mr. Charles A. Wolverton, *House Hearings on H.R. 1362*, 79th Cong., 1st Sess., Part 1, p. 247; Mr. J. Carter Ford, in *ibid.*, Part 2, p. 463.

portation industry. A more precise delimitation of what is included will clarify the matter of coverage.

Employers. The act extends not only to railroads, as the title would seem to indicate, but it extends also to express, railroad terminal, and sleeping-car companies subject to the control of the Interstate Commerce Commission, and includes any company owned or controlled by carriers that operate any equipment or facility or perform any service in connection with the transportation of passengers or property by railroad or with the servicing of that transportation, except trucking service.

Coverage also extends to railroad and traffic associations, tariff, demurrage and weighing and inspection bureaus, and other similar organizations performing services connected with or incidental to railroad transportation, which are maintained wholly or principally by two or more railroads, express and sleeping-car companies, or their affiliates.

Electric railways may or may not be included. They are not included unless operated as part of a general steam-railroad system. But a mere change in motive power from steam to electricity, or to any other source of power, will not remove a line from coverage. The Interstate Commerce Commission will determine in disputed cases whether any line operated by electric power is excluded. Bus lines are covered if operated or controlled by a covered employer.

Carrier affiliates performing trucking service, and casual operations of railroad equipment or facilities are not covered. The mining operations of coal companies owned or controlled by railroads and coal mining departments directly operated by carriers have been specifically excluded.

Furthermore, coverage extends to railway labor unions which are national in scope and organized in accordance with the provisions of the Railway Labor Act, and to their state and national legislative and general committees, their insurance departments, and their local lodges and divisions. Employee organizations existing only to provide sick and accident benefits or for the education of their members are not included as employers.

Employees. Nearly everyone who works for a covered employer is covered by the Act, whether working within or without the United States, provided the employer controls or supervises the manner in which his services are rendered, or if he is rendering integrated pro-

fessional or technical services, and he works for pay. However, an employee who works for an employer, other than a labor organization, the principal part of whose business is not in the United States is covered only while working in the United States. Mexico and Cuba require companies operating in those countries to employ a certain proportion of citizens or residents. The Act therefore does not include noncitizens and nonresidents working in a foreign country when the laws of that country require the employer to hire citizens or residents.

All service rendered for a local union lodge or division is covered, no matter where rendered, if all or substantially all of its members are employees of employers whose principal business is in the United States. But the employees of national labor union local lodges or divisions are not covered unless they were employed by a carrier on or after August 29, 1935.

Employee Annuities. Three general types of benefits are payable under the amended act: age, disability, and survivor. The pattern is not identical with that laid down in the Federal Old-Age and Survivors system. Under the railroad act, disabled workers may retire on an annuity. Railroad service of less than 10 years is credited under the Federal Old-Age and Survivors Insurance system for retirement and survivor benefits. Amendments effective late in 1951 introduced into the system benefits for wives, husbands, and widowers, much like those in the general Federal system.

Age Annuities. On retirement, employees who are 65 or over—60 for women with 30 years of service—and who have at least 10 years of creditable service are eligible to receive life annuities. Women who have attained the age of 60 and who have completed 30 years of service are eligible for the retirement annuity without any reduction in its amount, but the size of the annuity depends on compensation and length of service. Very few women accumulate 30 years of covered service. Optional retirement at age 60 is permitted for men with 30 years of service, but computed annuities in their cases are reduced by 1/180th for each calendar month under age 65 at the time the annuity begins to accrue, and this reduction is not restored when the annuitant reaches 65. The reduction is applied to the minimum as well as to the maximum. A person accepting an age retirement annuity must relinquish all rights to return to the service of his last employer or to covered in-

dustry, and no annuity is payable for any month in which such service is rendered for compensation. The "last employer" may not be a "covered" employer, and would not be if the annuitant had left the railroad industry and found employment elsewhere before retiring.

Disability Annuities. Two types of disability annuities are provided. One of these is payable to individuals who have a "current connection" with the railroad industry and whose permanent physical or mental condition disables them for employment in their regular occupation in the railroad industry, provided they have either completed 20 years of service or have attained the age of 60. This annuity is designed primarily for men who lose their regular jobs because of the exceptionally high standards of physical and mental competence applied, and whose skill and age will not enable them to secure other jobs paying anywhere near comparable amounts.

The Board, in cooperation with employers and employees, establishes standards for determining what constitutes permanent physical or mental disability for the different occupations in covered employment, and will strive to secure uniformity in the application of those standards. For occupations in which no standards are established, the Board is to apply practices generally prevailing in that occupation or in some comparable occupation.

Any employee so disqualified by an employer in accordance with the established standards shall be considered by the Board to be disqualified. In other words, the Board will not question the employer's judgment. Nor will the Board compel an employer to disqualify a worker. But if an employer does not so disqualify an employee and if the employee wishes to be disqualified, the Board may nevertheless grant him an annuity, if the employee quits and claims a disability annuity.

For the purpose of all annuities, and for the purpose of survivor benefits as well, one has a "current connection" with the railroad industry who, at the time his annuity accrues, has been in service as an employee for at least 12 months out of any 30 consecutive months before the annuity accrues. If these consecutive months do not immediately precede the month in which the annuity accrues, then the employee must not have been regularly employed in other than covered employment between the end of the 30 consecutive months' period and the month in which the annuity begins to accrue. Regular employment means the principal occupation during the last

five calendar years of employment, or if the employee so desires, then the principal occupation during the past 15 years.

The second type of disability annuity is payable to individuals whose permanent physical or mental condition disables them for any regular employment, provided they either have completed 10 years of service or have attained the age of 60, and without reference to a "current connection" with the industry.

A disability annuity ceases if the disability ends before the annuitant becomes 65 years of age. The formerly disabled person may later qualify for an old-age annuity, the amount of which will not be reduced on account of the previous payment of a disability annuity. A disability annuity will not be paid to any individual under age 65 for any month in which he receives more than \$100 in wages or self-employment income. In computing the annuity, only months in which wages were paid are counted, and presumably no wages would have been paid during the period of disability.

No annuity is paid for any month in which an individual receives any pay for work in covered employment or for work done for the "last" person who employed the individual prior to the date on which the annuity begins to accrue. This restriction is broader than that contained in the Federal Old-Age and Survivors Insurance plan, which permits limited earnings in covered employment, but it does not altogether remove the annuitant from the labor market, and is not intended to do so. Incidentally, the payment of an annuity to a disabled worker does not relieve the employer from liability to pay damages for personal injury, should there be any such liability.

Size of Annuities. The size of an annuity depends upon the amount of compensation received and years of service. Compensation does not include tips, or taxes levied on employees which are voluntarily paid by the employer and not deducted from the employee's pay. A year of service consists of any 12 calendar months of service, consecutive or otherwise, and regardless of the number of employers involved, in which a worker was employed and received wages in covered employment. A fraction of six months counts for a whole year if the employee has had at least 54 months of service, otherwise it counts only at its face value. A month of service consists of any calendar month in which an employee rendered service, even if that service was for as little as one day.

The Formula. Specific annuities are computed by taking 2.76 percent of the first \$50 of average monthly compensation, 2.07 per-

cent of the next \$100, and 1.38 percent of the next \$200, and multiplying the sum of these by the number of years of service.⁸

Creditable Service. For those employed on August 29, 1935, which is the date of original enactment, all service subsequent to December 1936 is counted, but if the total amount of this service is less than 30 years, then service rendered prior to January 1, 1937, may also be counted in order to bring the total up to a maximum of 30 years.

Service rendered prior to January 1, 1937, is counted in the reverse order to its occurrence. There is no statutory limitation on the number of years of service rendered after December 31, 1936, including service after age 65, that can be counted in computing the amount of the annuity.

There has been some shifting in the treatment of service after age 65. Before 1946, earnings after the month in which age 65 was attained could be counted toward retirement and survivor benefits if they increased the annuity. The 1946 amendment eliminated those earnings in the computation of retirement benefits but allowed them in the computation of survivor benefits if the size were thereby increased. The 1951 amendments again allowed both for all benefits. Since 1954 earnings may be disregarded, but service is counted. However, if the service after age 65 was rendered before 1937, it may not be used to increase the maximum of 30 years allowed to those who count service before 1937.

Military Service. Military service during periods of war or national emergencies is creditable in counting length of service, if the person entitled to it files a claim for credit. Such service is creditable only if the individual was employed by a covered employer during the same year in which he entered military service, or in the calendar year immediately preceding. For every month in wartime service, the employee's account is credited with \$160, except that for service before 1937, the amount credited is normally the average for the period 1924-1931.⁹ Military service rendered during a war

⁸ Before the 1954 amendments, the formula was 2.76 percent of the first \$50 of the average monthly compensation, 2.07 percent of the next \$100, and 1.38 percent of the next \$150. Between 1948 and 1951 they were 2.4, 1.8, and 1.2, respectively.

⁹ Military service after June 14, 1948, is counted only for (1) those in creditable military service on that date and who are required to continue in service beyond that date, and (2) those who enter military service involuntarily after June 14, 1948, and whose induction was preceded by railroad service in the same or preceding calendar year.

period after 1936 will also count as "quarters of coverage" in determining a worker's insured status when awarding survivor benefits. This will be discussed below.

The Federal government pays the extra cost for military service. For service before 1937 it pays the actual cost, and for service since 1936 it pays the combined employer-employee contribution on an assumed monthly wage of \$160. However, any increase in an annuity resulting from the application of this provision is to be reduced by the amount of any other Federal benefits payable for that same military service, such as military pensions. The net effect of this is that military service almost never increases the railroad retirement annuity of those receiving military pensions, although it not infrequently does increase disability annuities. Lump-sum death benefits, described below, are increased \$6.40 per month for military service before 1946, and \$11.20 for subsequent service.

The accrued cost to the Federal government, excluding interest, amounted to \$63,119,000 by the end of June 1944, \$1,364,000 being for military service performed before 1937. No employee annuity based in part on military service rendered after 1936 had yet been certified by the end of June 1944. The bulk of these certifications will come about 1970, when men now young will reach retirement age. Furthermore, survivor as well as disability and death benefits reflect military service, and they will add to the total cost.

Wages Counted. Average monthly compensation is computed from earnings, not counting amounts in excess of \$300 per month, paid in the calendar months included in years of service, except that when service prior to January 1, 1937, is counted, average earnings for the years 1924-1931 inclusive are applied to the entire amount of prior service counted, in order to simplify the examination of old records. For Red Caps whose pay was wholly or primarily in the form of tips, the period is September 1940-August 1941. When these years are inadequate or insufficient to constitute a fair and equitable basis, the Railroad Retirement Board will determine the annuity in a fair and equitable manner. Wages paid for time lost are counted as remuneration, as well as wages paid for reduced earnings resulting from demotion to a less remunerative job. Only months in which some compensation was paid are counted in computing the average monthly compensation.

Minimum Annuities. There is no specified maximum monthly annuity, although wage and service credit limitations will result in

an effective maximum of about \$169 monthly for the near future. But there is a provision regarding the minimum annuity. For those who have a current connection with the industry a minimum annuity is guaranteed equal to whichever one of the following is least: \$4.14 times years of service; \$69; average monthly compensation. But in no case is this minimum to be less than the amount that would have been yielded had all the employee's service since 1936—that under the Social Security Act as well as that under the Railroad Retirement Act—been creditable for benefit purposes under the Federal Old-Age and Survivors Insurance Act. This provision, adopted in 1951, brings a marked increase in minimum benefits of railroad workers and their survivors.

Spouse's Annuity. The spouse of an insured employee who has attained age 65 and who is receiving an annuity or pension is entitled to an annuity equal to one-half of the insured's annuity or pension, up to a maximum of \$40, provided the spouse has attained age 65. This annuity is payable also to a wife under age 65 if she has in her care her husband's child or children, unmarried and under 18, or a permanently totally disabled child over 18 who was so disabled before age 18. Added in 1951, the spouse's benefit fills the last major gap in benefits for railroad workers and their dependents.

Survivor Annuities. A system of annuities and lump-sum payments for survivors, roughly similar to those under the Federal Old-Age and Survivors Insurance system, was provided for in 1946, effective January 1, 1947, thereby filling what at that time was one of the wide gaps in the benefit structure of the Railroad Retirement system.

Widow's and Widower's Annuities. The widow, or widower, of a "completely insured" worker is entitled to a monthly payment equal to the insured worker's "basic amount." This becomes payable at age 60; it continues until death or remarriage. But if a greater spouse's annuity was payable before death, the annuity is increased to that amount. The terms "basic amount" and "completely insured" will be defined below.

A widow's current insurance annuity, which is also equal to the deceased husband's basic amount, is provided for the widows of completely or "partially" insured individuals who have in their care a child of the deceased who is entitled to a child's insurance annuity. This annuity ceases at death or remarriage, or if and when the

widow becomes entitled to a widow's insurance annuity, or when she no longer has in her care a child entitled to a child's annuity, whichever occurs first.

The Child's and Parent's Annuities. A child's insurance annuity, equal to two-thirds of the deceased parent's basic amount, is payable to children of completely or partially insured individuals. A parent's insurance annuity, equal to two-thirds of the deceased employee's basic amount, is payable to parents of completely insured individuals who die without leaving a widow or child. The parent must be at least 60 years of age to qualify.

The Funeral Benefit. Should any insured person die leaving no one entitled to an annuity for the month in which death occurred, a lump-sum benefit equal to ten times the basic amount is payable to the widow or widower if living, otherwise to a living child or children, otherwise to the person or persons who under state law would be entitled to it. If the lump sum is paid to a nonrelative who bears the funeral expenses, it will not exceed the funeral expenses.

The qualifications for widow, child, and parent, in so far as payment of annuities is concerned, are the same as in the Federal Old-Age and Survivors Insurance system. A widow must have been living with her husband employee at the time of his death; a child must have been dependent on the parent at the time of his death, unmarried, less than 18, and not adopted after his death; and a parent must have been dependent upon the employee for at least one-half of his support, and proof of such dependency and support must have been filed with the Board.

Insured Status. An individual is "completely" insured if he has 10 years of service and (1) if he had a current connection with the railroad industry, had at least six quarters of coverage and a minimum of one-half the quarters elapsing since 1936 or after the quarter in which he became 21, whichever was later, and before the quarter in which he died or became 65, whichever was the earlier, as in the Federal Old-Age and Survivors system, but excluding any quarter in which an old-age or disability annuity was payable to him; or (2) if he had a current connection with the railroad industry and 40 or more quarters of coverage; or (3) if a pension was payable to him, or a retirement annuity based on not less than 10 years of service began to accrue to him before 1948. These last two provisions are designed to provide benefits to survivors of individuals

on the annuity or pension rolls before survivor benefits were incorporated into the law, even to survivors of employees who have for some time been dead.

An individual is "partially" insured if at death he had at least 10 years of service, had a current connection with the industry, and had at least six quarters of coverage in the period beginning with the quarter of his death and extending back to include the three calendar years preceding the year in which he died.

Wages and service in employments covered by the Federal Old-Age and Survivors Insurance system are counted along with compensation and service under the Railroad Retirement system in determining survivor benefits. More than half of those covered by the Railroad system have also been covered by the general Federal system.

TABLE 16. Railroad Retirement System: Compensation and Quarters of Coverage Allowed ¹⁰

Total Compensation Paid in Calendar Year	Number of Quarters According to Specified Months of Service			
	1-3	4-6	7-9	10-12
Less than \$50	0	0	0	0
\$ 50 - \$ 99	1	1	1	1
100 - 149	1	2	2	2
150 - 199	1	2	3	3
200 or more	1	2	3	4

Quarters of Coverage. A "quarter of coverage" may be acquired under either the Federal Old-Age and Survivors Insurance system or the Railroad Retirement system. Under the former, it consists of a quarter in which at least \$50 was received in wages or \$100 in self-employment income in covered employment. This is called a "wage quarter of coverage." If acquired in employments covered by the Railroad system, it is called a "compensation quarter of coverage," and is computed according to Table 16.

If using this procedure does not result in complete or partial insured status, and if presuming that compensation had been paid in equal proportion for each month of the year will do so, then that presumption will be made. No one individual may be credited with

¹⁰ Jack M. Elkin, *Social Security Bulletin*, December 1946, p. 24

more than four quarters of coverage for any single calendar year.

Social Security Coverage. Railroad employees with less than 10 years of service in that industry, excepting those awarded annuities before October 30, 1951, are taken out of the system entirely. Their earnings in the railroad industry since 1936, and in employment and self-employment covered by the Social Security Act, are all credited under the latter system. Their benefits, both retirement and survivor, are payable by that system and computed according to its formulas. Even the service of noncitizens working in countries that require the employment of specified percentages of native labor is credited.

For those with 10 years or more of creditable railroad service and for their survivors and dependents, the two systems are interrelated by a minimum guarantee provision. Railroad retirement and survivor annuities must at least equal what would have been yielded by railroad service rendered since 1936 plus any social security coverage the employee might also have had, assuming that all the railroad service was creditable under the Federal Old-Age and Survivors Insurance system. The retirement annuity itself will in general be only slightly affected by this provision, except for those with but little more than 10 years of railroad service. However, an important result is that for the next ten years or so most railroad survivor annuities will be based on Federal Old-Age standards. When survivor benefits are increased by this minimum guarantee, no credit is allowed for railroad service prior to 1937.

Benefits paid on the basis of the Federal Old-Age system are computed from the employee's "basic amount," which is comparable to the amount used in that system for computing benefits paid to those not covered by the "new start" formula. Except for pensioners, the basic amount is derived by taking 40 percent of the average monthly remuneration up to \$75, plus 10 percent of the amount over \$75 up to and including \$350, plus 1 percent of the sum of these two for each year in which the employee was paid at least \$200. In computing the average monthly remuneration, earnings—including those from employment and self-employment creditable under the Federal Old-Age system—up to a combined maximum of \$3600 a year, are counted. For those retired on pensions, the incremental factor of 1 percent per year is not used. This amount is then used with the Social Security Act conversion table to derive the benefit amount.

Money transfers between the two Trust Funds are made to keep

the Federal Old-Age system in the financial position it would have been in had the railroad workers involved been, and continued to remain, covered by that system.

Combined Annuities and Deductions. Railroad annuitants entitled to monthly benefits under both the Railroad Retirement Act and the Social Security Act in effect receive the higher of the two. This is true even of a wife entitled to a benefit based on her husband's railroad service and to a primary benefit under the general system based on her own earnings. But the wife may receive a wife's benefit under each of the two programs at the same time. However, since the husband's railroad annuity will generally be reduced if he also receives an old-age insurance benefit, the wife's railroad annuity will also be reduced. Until the Act was amended in 1954, widows, widowers, and parents entitled under the Railroad Retirement Act to a retirement annuity based on their own earnings and also to a railroad survivor's annuity received the higher of the two. Now they receive both.

For combined family benefits there is a maximum of \$160 or 2% times the basic amount, whichever is smaller, but no reduction below \$30 will be made, and there is an absolute minimum of \$14. The social security minimum guarantee will increase these benefits in many cases. Employee annuitants suffer deductions if they earn anything in the railroad industry or from their last employer; dependents and survivors may earn in social security employment the maximum allowed by that system. Children not attending school regularly, if attendance was feasible, had their annuity deducted until after the amendments of 1954.

Pensions. It will be recalled that when the Railroad Retirement Act was passed more than 50,000 railroad workers were receiving pensions voluntarily granted by the carriers. These pensions were blanketed into the retirement system, being granted as a right rather than as a gratuity. The entire cost is borne by the Railroad Retirement system. Persons receiving such pensions on both March 1 and July 1, 1937, and who were not eligible for the regular annuities, are paid their pensions, including a restoration of any reduction made in them after December 31, 1930, but none of these pensions could exceed \$120 per month. Beginning in July 1948, the pensions were increased by a flat 20 percent. Railroads may, to be sure, pay more than this amount out of their own money if they want to do so. Further increases were made in 1951.

Death Benefits

Under the Act of 1935. The act of 1935 provided for the payment of death-benefit annuities to the surviving spouse or dependent next of kin of deceased annuitants or employees entitled to receive an annuity under the Act. They consisted of one-half the amount of the single-life annuity, and were payable for a period of 12 months only. Those death-benefit annuities were continued in the Act of 1937, payable only on account of annuities granted under the Act of 1935. Practically all of the persons who were eligible for annuities under the Act of 1935 have had them granted, and it is simply a matter of time before this feature of the Railroad Retirement system disappears. The receipt of this benefit, it should be noted, does not affect any person's subsequent right to a monthly annuity.

Residual Payment. Before monthly survivor benefits similar to those provided in the Federal Old-Age and Survivors Insurance system were established in 1946, there was a lump-sum death benefit paid in cases where an insured person's death occurred. If the death occurred before an annuity began, the amount was equal to 4 percent of the total credited compensation received by the deceased after December 31, 1936. In case the annuitant died before having received an amount equal to 4 percent of that compensation, the difference would be paid. It was necessary that the person qualified to receive this benefit apply for it within two years from the date of death. When an applicant died after the date on which his annuity began but before payment had actually been made, the annuity was nevertheless certified if the amount involved was greater than the death benefit. Where a joint-and-survivor election had been made, the survivor annuity was certified.

That lump-sum death benefit was replaced by the survivor benefits established in 1946. However, many workers believed that they and their families might not receive in benefits as much as they had paid in taxes, and they felt themselves aggrieved. To meet their objections, the 1948 amendments restored the benefit.

The new residual payment provides a guarantee that each covered worker and his survivors will receive in benefits more than the worker paid in taxes, including any amount paid on his behalf by the Government on account of military service, both accrued at interest. The worker's right to designate a beneficiary to receive a residual payment is restored.

The residual payment is a lump sum equal to 4 percent of the worker's creditable compensation since 1936 through 1946, and 7 percent on compensation since 1946, including wage credits of \$160 for each month of military service minus all benefits paid to annuitants and survivors which are based on railroad and military compensation. It will be paid only when no immediate or future monthly benefits are payable, or if the widow or parent remarries or dies, or if the person who might be entitled to monthly benefits at age 65 elects to waive all rights to those monthly benefits and receive immediately the residual lump-sum payment instead. The election must be made before the survivor reaches age 65, otherwise the residual payment, if any is then due, will be made only after the monthly survivor benefits have ceased.

Joint-and-Survivor Annuities. Provision was at one time made for joint-and-survivor annuities, but it was repealed in 1946, although those having elected such annuities were permitted to continue them. Employees so desiring and who so elected at least five years before their annuities began to accrue, or who furnished proof of health satisfactory to the Board, could provide their widows with annuities. Three combinations were offered: option A, under which the widow received as much as her deceased spouse had received; option B, in which she received three-fourths as much, and option C, in which she received one-half as much. Each combination was actuarially equal to the single-life annuity which the employee would otherwise have received. In other words, the husband merely shared his annuity with his wife. Once election was made, it was irrevocable unless the employee or his spouse died before the annuity began to accrue, or there was a divorce, or if the annuity was for disability. The wife's annuity began to accrue in the month of her husband's death, irrespective of her age. Only a few employees elected this type of annuity. No joint-and-survivor election was permitted after July 30, 1946. A valid election already made by an employee to whom an annuity is awarded after July 30 with a beginning date before 1947 remains valid unless he revoked the election by July 31, 1947. An election already made by an employee to whom an annuity accrues after 1946 becomes inoperative unless he reaffirmed the election before 1948. Because the 1951 amendments introduced a spouse's benefit, a worker may now revoke his election and have his annuity fully restored. An election is automatically revoked when the spouse for whom it was made dies.

Financing

Taxes. A separate act was passed to raise the money needed for the annuities provided, and this was done, it will be recalled, in order to avoid, if possible, the constitutional hurdle. The tax consists of three parts: an excise tax on employers, an income tax on employees, and an income tax on employee representatives. It is based on compensation received not in excess of \$350 per month. By agreement between unions and carriers, equal rates are levied on employees and employers, beginning with 2.75 percent each for the years 1937-1939 inclusive and increasing $\frac{1}{4}$ of 1 percent every three years thereafter through 1945. The rates were continued at 3.5 percent through 1946. For 1947-1948 they were 5.75 on each, and 6.0 for 1949-1951. They were raised to 6 $\frac{1}{4}$ percent in 1952. The combined sum of 12.5 percent represents a substantial proportion of the pay roll, but it purchases substantial benefits.

The employer is made liable for the amount of the employee's tax and deducts that amount from the worker's pay. When an employee works for two or more employers, the Commissioner of Internal Revenue is supposed to decide the proportions of the taxes to be deducted by each employer. No serious problem arises here, of course, unless such an employee earns more than \$350 per month.

The rate on employee representatives has been and will continue to be equal to the sum of the rates levied on employer and employee combined. They are thus equal to what the representatives and their employers would pay if they were working for the carriers instead of the unions.

The Federal government has obligated itself to pay the annuities provided by this retirement system. Money collected under the taxes levied goes into the general fund of the Treasury. It is intended that the taxes shall provide all the money needed, but it is not unlikely that there would be some resistance on both sides to further rate increases. The Act authorizes the appropriation from the general fund of an annual premium sufficient when compounded at 3 percent annually to pay the annuities. Annually the Railroad Retirement Board submits to the Bureau of the Budget an estimate of the amount needed to meet estimated accrued liabilities. Thus it is definitely intended to be a "reserve" rather than a "pay-as-you-go" system, and provision is made for periodic actuarial studies and reports on the status of the fund in relation to accrued liabilities.

Railroad Retirement Account. A Railroad Retirement Account

is established in the Federal Treasury, and amounts not immediately needed by the Board to pay benefits and administrative costs are invested in United States obligations or in obligations guaranteed as to both interest and principal by the United States. Special obligations bearing 3 percent interest may be issued for this purpose.

Actuarial Valuations. Every three years the Board must make actuarial estimates of the amounts necessary to maintain the solvency of the system. The Act provides that the Board shall appoint two members of an Actuarial Advisory Committee of three to check its own figures and methods. One of these is selected from recommendations made by representatives of the carriers, one from recommendations made by representatives of the railroad unions, and the third is designated by the Secretary of the Treasury. This committee is strictly advisory and it recommends to the Board such changes in actuarial methods as may be deemed necessary. But the Board is not required to accept those recommendations.

Administration. The system is administered by the Railroad Retirement Board, which consists of three persons appointed by the President with the approval of the Senate, for overlapping terms of five years. One of these must be selected from recommendations made by representatives of the employers and one from recommendations made by representatives of the employees, and the persons so selected must be "satisfactory to the largest number" of employers and employees. In effect this means persons recommended by the Association of Railway Executives and the Association of Railway Labor Executives. The third member, who is the chairman, may be thought of as representing the public, and he is not to "be in the employment of or be pecuniarily or otherwise interested in any employer or organization of employees. . . ."

The Board is an independent agency located in the executive branch of the Government and is not subject to the control or direction of any department or of the Social Security Administration. Only the President has any control over it, and even that is limited by the provision that two of the three members must be selected from nominations made by representatives of employers and unions. A quorum consists of a majority of the members in office.

In employing personnel, the Board is subject to Civil Service laws and to the rules of the Civil Service Commission. However, the Board is required to give preference to individuals with railroad experience, if the Board believes that they possess the necessary

qualifications, and "no other preference shall be given or recognized." Veterans' preference exists here as in other Federal agencies.

Rules and regulations for the conduct of the system are made by the Board and when all three positions are filled the rules, regulations, and decisions must have the approval of at least two of the members.

In determinations "relating to pensions, annuities, or death benefits," the Board's decisions are not "subject to review by any other administrative or accounting officer, agent, or employee of the United States," including the Comptroller General.

The Board also administers the Railroad Unemployment Insurance Act, under which it pays unemployment, sickness, and maternity benefits, and it operates a network of employment offices.

There is within the Board a Bureau of Retirement Claims. This Bureau adjudicates all claims made for benefits and certifies those approved to the Treasury for payment. It also assembles and processes records of creditable service and compensation for the period before January 1, 1937.

Decisions made by the Bureau on retirement benefits may be appealed to an Appeals Council. This Council consists of persons familiar with problems of employees and management, and a chairman who is trained in law. It is in effect a joint board with an impartial chairman. The Council is independent of the Bureau and is administratively responsible to the Board's Executive Officer. Decisions made by it may be taken directly to the Board.

There is recourse to the courts, but only after all administrative remedies within the Board have been exhausted. Any claimant, his railway labor organization if organized in accordance with the provisions of the Railway Labor Act, or any other party aggrieved by a final decision relating to annuities or coverage may appeal to the United States Circuit Court of Appeals for the circuit in which he resides, or to the Circuit Court of Appeals for the Seventh Circuit, or to the Circuit Court of Appeals for the District of Columbia. The Board's findings of fact, if supported by evidence and in the absence of fraud, are conclusive. The Court may not hear additional evidence, but may order the Board to take additional evidence which it may then consider. The Court may affirm, modify, or reverse the Board and may if it sees fit remand the case for a rehearing. Judgment and decree are final, but subject to review as in equity cases.

CHAPTER SEVEN

THE RAILROAD RETIREMENT SYSTEM: OPERATIONS

THE Railroad Retirement plan has been in operation for approximately 20 years, and a large body of experience has been accumulated. That experience will now be reviewed in order to reveal salient characteristics of coverage, wages, benefits, and finance and to indicate major trends. The most significant part of that experience has come since the 1946 amendments established monthly survivor benefits similar to those introduced earlier into the Social Security Act. The experience sheds some light on what might happen if the Old-Age and Survivors system provided permanent total disability benefits.

COVERAGE

The system is limited to one industry, but the coverage is none the less quite substantial, both in terms of employers and employees. In terms of size, the system has grown but little, and that little was the result of the war and the postwar boom.

Employers. The number of units held to be employers under the Railroad Retirement Act is not great. As of June 1952, there were 1737. Nearly all of these, 1362, were carriers. Carrier affiliates numbered 189, and carrier associations numbered 156. There were 30 railway labor organizations, including the Railway Labor Executives Association, the Railway Employees Department of the American Federation of Labor, and insurance departments of two labor organizations. In addition, there were 216 "employing units," not themselves employers, but service for whom was considered as service to a covered employer, such as contractors. There is some change from year to year in the total number of employers covered, more

perhaps than a layman would expect. A total of 440 different employers covered at one time or another ceased operations prior to January 1, 1951.

Employees. There has been considerable variation in the number of employees covered. Table 17 shows by calendar year the total and average numbers employed in the industry during the year, and the number in active service at the end of the year.

TABLE 17. Railroad Retirement System: Number of Employees, 1937-1951 ¹
(In Thousands)

Year	Total for Year	Average for Year	In Active Service at End of Year	Ratio of Total to Average
1937	1996	1279	1411	1.56
1938	1617	1093	1356	1.48
1939	1665	1151	1411	1.44
1940	1708	1195	1432	1.43
1941	2053	1322	1611	1.55
1942	2588	1470	1794	1.76
1943	2888	1591	1908	1.82
1944	2904	1670	1978	1.74
1945	3016	1680	1942	1.80
1946	2660	1622	1903	1.64
1947	2476	1598	1857	1.51
1948	2311	1558	1840	1.49
1949	2094	1403	1660	1.49
1950	2038	1421	1780	1.43
1951	2080	1479	1700	1.41

Variations in the numbers employed have been largely the result of the war and the preparations preceding it. The sharp recession of 1937 resulted in a slight decline in employment for 1938. After that, there was a steady increase, with a peak being reached in 1945. In addition to the greatly increased number of persons employed, there was a large amount of overtime, which affected the size of annuities and death benefits. Postwar employment remained remarkably high, although it is not yet clear at what level employment will become stabilized.

A marked volume of turnover exists in the industry, as shown by the ratio of total to average employment for the different years. In

¹ *Annual Reports of the Railroad Retirement Board.*

the year of highest turnover, which was 1943, it required on the average 182 persons to fill 100 jobs. Approximately 1,150,000 of those employed in 1945 left the industry, and in 1946 there were half a million new entrants, and 250,000 ex-servicemen returned. That large volume of turnover is the principal explanation for the exceedingly large number of persons acquiring credits in the system. Not all of these will later become annuitants.

TABLE 18. Railroad Retirement System: Age Distribution of Employees with Credited Compensation, by Specified Year ²
(In Thousands)

Age	1937		1940		1945		1949	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total	1738	100 0	1662	100 0	3085	100 0	2090	100 0
Under 20	41 3	2 4	35 8	2 2	299.0	9 7	53 7	2.6
20-24	183 3	10 5	178 2	10 7	336 0	11 0	241 0	11.6
25-29	170 0	9 6	170 9	10 3	357 0	11 6	240 9	11 5
30-34	190 9	11 0	166 0	10 0	340 0	11 1	226 4	10 9
35-39	223 9	12 9	190 7	11 5	331 0	10 8	212 3	10 2
40-44	222 7	12 9	215 0	12 9	335 0	10 9	216 3	10 4
45-49	217 6	12 7	208.4	12 5	327 0	10 6	234 8	11 3
50-54	178 7	10 5	193 0	11 6	276.0	9.0	217 5	10 4
55-59	139 9	8 0	155 4	9 4	229 0	7.4	196 0	9 4
60-64	93 6	5 2	101 8	6 1	156.0	5 1	157 3	7.5
65-69	56 1	3 2	38 5	2 3	68 0	2.2	72 7	3 5
70 and over	19 6	1 1	8 1	0 5	18 9	0.6	17 1	0.8
Median Age	41		42.1		38.1		41.6	

Age Distributions. Workers covered by the Railroad Retirement Act are on the average considerably older than those covered by the Social Security Act. For 1937, and counting only workers under 65 years whose ages were known, 70 4 percent of those covered by the Social Security Act were under 40, while only 46 6 percent of the railroad workers were under 40. But the age pattern for railroad workers has changed appreciably since the retirement system was inaugurated, as the figures in Table 18 show.

The war not only increased the number of persons employed,

² *Annual Reports of the Railroad Retirement Board, The Monthly Review*, October 1947, p. 218

but it also greatly increased the proportion in the younger-age groups. The median age declined from 42.1 years in 1940 to 38.5 in 1942 and to 38.1 in 1945. Transportation was so critical during the war that young men employed in the industry were deferred from military service in large numbers. Older men were led to stay on for both patriotic and financial reasons. The number in active service at the end of the year increased from 39,600 in 1941 to 59,800 in 1945—from 2.5 to 3.1 percent of all employees. For 1951 there were 69,000, or 4.1 percent of all employees. It has remained high.³

Compensation. The total amount of taxable compensation paid to workers covered by the Railroad Retirement Act and the average per individual, by years, are shown in Table 19, page 160.

Total compensation declined slightly more than 10 percent in 1938, because of the sharp business recession in that year. But as a result first of defense preparations and later of war activity, employment and wages increased markedly and total compensation paid went up to \$4.7 billion in 1947. Total compensation remained high for some years after the war. Average compensation is not high. The average for 1938 was only approximately \$1243, but by 1944 it had reached \$1482, and climbed to \$2456 in 1951. Wage increases and lower total employment had raised the average to \$1920 for

³ There is a close relationship between age and continuity of employment. For employees who were employed each of the years 1937–1945, the median age in 1945 was 51.8. In 1942 the median age of those with 12 months of service during that year was 46.7 years, while the median for those with less than 12 months was only 32.6, a difference of over 14 years. Only 19.4 percent of those with 12 months of service were less than 35 years of age, while 56.5 percent of those with less than 12 months were under 35. Again, 24.6 percent of those with 12 months of service were 55 or over, while only 10.6 percent of those with less than 12 months of service fell into these age groups. This distribution is distorted by the effects of wartime employment and by seniority regulations in the railroad industry.

More significant in the matter of age distributions than length of employment are the various occupational classifications. Median ages of professional, supervisory and skilled classifications are considerably higher than for others. In 1940, the median age for engineers was 56.1; for executives, professional and supervisory, 50.1; for station agents, telegraphers and gang foremen, 49.7; for skilled maintenance-of-equipment workers, 48.1; for firemen and brakemen, 45.6; for skilled maintenance-of-way and structures workers, 44.0. All the rest were under the median age of 42.1, and the youngest were the extra-gang men, whose median age was only 28.6. War employment affected this distribution, but it would appear to be fairly close to normal except for the unskilled and clerical groups, which normally would have somewhat higher median ages. The median ages in 1945 were down slightly.

TABLE 19. Total Taxable Compensation Paid to Workers Covered by the Railroad Retirement Act, by Year, 1937-1951 ⁴

Calendar Year	Taxable Compensation	
	Total (In Millions)	Average
1937	\$2259	\$1131
1938	2003	1243
1939	2140	1288
1940	2243	1317
1941	2651	1295
1942	3296	1277
1943	3938	1367
1944	4295	1482
1945	4333	1440
1946	4632	1745
1947	4744	1920
1948	4943	2135
1949	4598	2200
1950	4698	2310
1951	5109	2456

1947. However, these average figures do not have too much significance, for they include the earnings of a very large number of workers employed for very short periods of time.⁵

A distribution of workers by amount of credited compensation shows a heavy concentration in the low brackets, as would be expected where many are employed for short periods of time. From one-fifth to one-fourth receive less than \$200 annually. Many of those no doubt earn some income in noncovered employment. The number who receive the maximum amount of creditable compensation is exceedingly small, and for a great many years constituted less than 2 percent of the total number employed. There is a high

⁴ *Annual Report of the Railroad Retirement Board, 1951-1952; The Monthly Review*, July 1948, p. 133, and August 1948, p. 165

⁵ The percentage of the total working force employed for the entire 12 months was 52.6 in 1937, reached 63.0 in 1940, and declined to 45.1 in 1944. The percentage employed for only one or two months varied from 13 in 1939 to 26.3 in 1945, and approximately 62.7 percent of those were in 1945 employed only one month. The percentage employed four months or less varied from 19.7 in 1940 to 37.4 in 1945. The remainder were fairly evenly distributed among the other total number of months of employment, except for those employed for 12 months, who in 1945 constituted 43.3 percent of the total

degree of correlation between amount of earnings and length of employment. Practically all in the top-income brackets were employed the year round.

BENEFITS

Before 1947, the railroad system's benefit structure consisted of retirement and disability annuities paid to employees, joint-and-survivor annuities when elected voluntarily by some employees in lieu of their standard annuities, pensions formerly paid gratuitously by railroad employers to certain of their older retired workers, a small class of severely limited survivor benefits, and a residual lump-sum benefit which served as a guarantee that the employee and his survivors would receive at least the amount of taxes paid into the system, with interest. Essentially it was a simple retirement system. That structure was altered drastically by amendments made in 1946, which introduced annuities for survivors and dependents and a funeral benefit. A spouse's annuity, it will be recalled, was added in 1951. The benefit structure is now a well-rounded one, more so than that of the Federal Old-Age and Survivors Insurance system.

Totals. Table 20 shows the total number of monthly benefits of all types awarded under the Railroad Retirement Act, the number of them in current-payment status at the end of the year, and the amount of benefits paid, by years, since the inception of the system. The total number of benefits awarded has increased slowly. Some difficulty was experienced by the Board in securing employee service records prior to 1937 and consequently the Board was slow at first in certifying benefits. The big backlog of annuitants and pensioners was put on the rolls in 1937-1939. The next sharp increase in total awards came in 1946-1948, when what was essentially a simple retirement system was changed into one that provided also for survivors. A similar increase occurred in 1951-1952, when the new spouse's benefit was first awarded. The total number of awards made annually is now smaller than it otherwise would have been because the accounts of railroad employees with less than 10 years of service in the industry are transferred at death or retirement to the Federal Old-Age and Survivors Insurance system. A study of dual coverage in the period 1937-1950 made by the Board showed that there were 6,420,000 employees with earnings under both systems and that 6,190,000 of them had less than 10 years of railroad

TABLE 20. Railroad Retirement System: Total Number of Monthly Benefits Awarded, Number in Current-Payment Status, and Amount of Payments in June, by Fiscal Year ⁶

Fiscal Year	Number Awarded	In Current-Payment Status at End of Year	Benefit Payments in June
1936-37	7,527	7,223	\$ 851,266
1937-38	109,574	108,240	8,436,380
1938-39	37,688	132,239	9,108,744
1939-40	25,257	144,290	9,869,510
1940-41	22,217	153,094	10,349,958
1941-42	17,611	156,963	10,800,027
1942-43	17,464	160,045	11,088,360
1943-44	19,284	164,125	11,375,847
1944-45	21,827	171,452	12,246,147
1945-46	28,392	185,137	13,363,565
1946-47	62,913	231,213	16,648,472
1947-48	120,629	320,140	19,147,472
1948-49	66,960	356,155	24,493,161
1949-50	64,814	387,329	26,161,926
1950-51	56,872	407,871	27,050,889
1951-52	136,726	503,093	38,925,348
1952-53	104,400	531,100	40,436,437

service. By the end of June 1953 nearly one million monthly awards had been made.

The number of monthly benefits in current-payment status—that is, actually being paid—has mounted steadily, experiencing marked increases first when the backlog was put on the rolls and then as new benefits became payable. The half-million mark was reached at the end of the fiscal year 1951-1952, during which the spouse's benefit first became payable. At the end of June 1953, 531,100 monthly benefits were in current-payment status.

The amount of money paid out increased slowly as the system acquired maturity, showing marked changes as the number and amount of monthly benefits increased, after 1946 and 1951 especially. In June of 1953 the monthly total exceeded \$40 million for the first time. In that fiscal year a grand total of \$460.4 million was paid out in retirement and survivor benefits, up considerably from the \$394.2 million paid during the preceding fiscal year. The total

⁶ *Annual Reports of the Railroad Retirement Board; The Monthly Review*, August 1953.

will continue to increase as the system matures still more and as the benefit formulas are further liberalized.

Table 21 gives a summary statement of benefit operations for the fiscal year 1952-1953. It shows the number of specific benefits awarded during that year, the number of current-payment status at the end of the year, and the average monthly amount paid for each of the benefits as of that date. Each of these benefits is discussed in some detail in the following paragraphs.

TABLE 21. Railroad Retirement System: Employee and Survivor Benefits for 1952-1953 ⁷

Class of Benefit	Number Awarded, 1952-1953	In Current- Payment Status, June 30, 1953	Average Monthly Amount, June 1953
Age	24,121	195,718	\$96.83
Disability	9,033	78,731	92.91
Spouse's	22,921	91,286	36.33
Aged widow's	13,261	96,520	42.79
Widowed mother's	2,296	12,504	51.42
Child's	4,658	46,165	33.21
Parent's	118	1,083	41.85
Pensions	...	4,735	79.29

Employee Annuities. The solid core of the Railroad Retirement system consists of annuities paid to employees on the basis of their employment and pay in the industry, although survivor annuities have assumed considerable importance. There are three types of employee annuities: age, disability, and pensions.

Age Annuities. Employees may retire at age 65 with their full annuities. Women with at least 30 years of service may retire at age 60 with full annuities. Men with at least 30 years of service may also retire at age 60, but with reduced annuities.

The total number of full age annuities being paid at the end of the fiscal year 1951-1952 was 170,800, and nearly one-half of these had been awarded since 1946. On the average, the retired annuitants were 73.7 years old, and 22,400 of them averaged more than 80 years of age. The average age of those whose annuities began in

⁷ *Ibid.*

1951 was 68.1 years. The average monthly amount received by these annuitants for December of 1951 was \$95.62.⁸

Railroad employees obviously hold tenaciously to their jobs. At the end of 1951, 4.1 percent of all railroad employees in active service were 65 or over, the highest percentage recorded since data became available in 1937, when the percentage reported was only 2.6. The proportion of those retiring immediately on attaining age 65 has shown a downward trend; it amounted to 16 percent in 1951. Since service and compensation after age 65 may now be counted in computing the monthly amount, the size of retirement annuities will increase, and some employees may well postpone retirement in order to receive higher annuities.

Not many receive annuities reduced because they retired, with 30 years of service, between ages 60 and 65. At the end of 1951 there were only 11,500 of these, their average age was 69.5 years, and their average monthly annuities amounted to \$93 95, which was very little less than the amount of the full annuities being paid.

During the fiscal year 1952-1953, a total of 24,121 age annuities, full and reduced, was awarded, 195,718 were in current-payment status on June 30, 1953, and the average monthly amount was \$96.83. However, the average of the annuities awarded during the fiscal year was \$105.32, as compared with \$94.61 for those awarded in the preceding fiscal year.

Disability Annuities. The railroad system provides that a disabled employee may receive an annuity. That this feature of the system is of vital importance is shown by the fact that on June 30, 1953, there were 78,731 of these annuitants on the rolls, slightly more than 40 percent as many as the age annuitants. The number of disability annuitants added to the rolls has declined steadily each year for some time. For example, in 1947-1948, 21,800 disability awards were made, whereas for the fiscal year 1952-1953 only 9000 were made. The average monthly amount paid was \$92 91, only slightly less than the average paid to age annuitants. Nearly three-fourths of the annuities ranged from \$60 to \$120. Most of the disabled annuitants

⁸ A distribution of all full age annuities in current-payment status on December 31, 1951, by size shows that 6 percent of them were for less than \$30, 7 percent ranged from \$30 to \$60, 24 percent from \$60 to \$80, 16 percent from \$80 to \$100, 29 percent from \$100 to \$130, 12 percent from \$130 to \$150, and 7 percent from \$150 to \$165.60. Thus 51 percent of those on full annuities were receiving less than \$100 a month. By contrast, the distribution for December 1945 showed that only 1.1 percent were receiving as much as \$120.

were older persons, the average age at the end of 1951 being 63 5 years. The average age of these annuitants has declined steadily since the system was first established; the average age of those to whom such annuities were awarded in 1951 was 59 years. Very few annuitants went on the roll before they were 50.

Pensions. When the Railroad Retirement system was adopted, 47,836 persons then receiving "gratuitous" pensions from railway companies that had established individual retirement programs were transferred to its rolls, and a few were added still later. They now constitute a "closed group," since others are retired under the provisions of the system, and they are gradually dying off. At the end of June, 1953, there were only 4735 in current-payment status, a decline of 17 percent as compared with the preceding year-end. The group was very old, averaging about 85 years. The average monthly benefit amount was \$72.29, having risen steadily from \$57.88 in June of 1937, and then declined somewhat. Approximately two-thirds of them had been pensioned by their employers because of disability rather than age. Shortly they will be numbered in the hundreds, and in due time none will be left.

Survivor Annuities. The railroad system first made provision for monthly survivor benefits in 1946, effective in January 1947; the spouse's annuity was not added until 1951. The structure of benefits for survivors and dependents is now similar to that in the Federal Old-Age and Survivors Insurance system, and in some respects the railroad system is superior.

Spouse's Annuity. As yet very little can be said about the spouse's benefit because it was so recently established. As of June 30, 1952, a total of 85,034 had been awarded and 80,559 were in current-payment status. This large number reflects the backlog that was put on the rolls immediately after the benefit was established. At the end of June 1953, the number receiving the spouse's benefit had grown to 91,286, a 13 percent increase over the preceding year. The average monthly amount received in June 1953 was \$36.33.⁹ It will be recalled that the spouse's monthly benefit amount may not exceed \$40. The wives of almost 40 percent of retired employees were receiving the benefit. As in the Federal Old-Age and Survivors Insurance system, a few dependent husbands of retired women employees were also receiving it.

⁹ *The Monthly Review*, August 1953, p. 146

Widow's Annuity. Before the amendments of 1946, a railroad employee, if he so desired, could make a joint-and-survivor election which paid him a reduced annuity on retirement but provided an annuity for his surviving wife after his death. These were not popular, despite efforts made by the Board to encourage their adoption. And they were not popular because the two combined were equal in value to the single-life annuity upon which they were based. In other words, the employee merely divided his annuity into two parts. Only 127 were elected in the fiscal year 1952-1953, only 4384 were in current-payment status at the end of that year, and the average amount being paid in June 1953 was \$45.65. As noted above, this type of arrangement serves no further purpose and will disappear altogether from the benefit structure.

The widow's and widower's annuity provides for the surviving spouse, without the necessity of an election. Through June of 1953, a cumulative total of 121,115 of these had been awarded. At the end of June 1953, there were 96,520 of them in current-payment status, slightly more than the number of spouse's benefits. The average monthly amount paid in June 1953 was \$42.79, which was somewhat higher than for the end of the preceding year.

Mother's and Child's Annuities. Through June 1953, a cumulative total of 32,171 benefits had been awarded to widowed mothers with children under 18 in their care. There were 12,504 in current-payment status as of June 30, 1953. The average monthly amount being paid as of that date was \$51.42, although it has increased somewhat since then. The average of those awarded in October 1953 was \$52.01.

The number of children's annuities awarded through June 1953 totaled 78,704, approximately 2.5 for each widowed mother's annuity. Nearly one-half of these awards were made in the two fiscal years 1947-1949, because there was a backlog of applications that were processed during those years. As of June 30, 1953, there were 46,165 children's annuities in current-payment status. The benefit is terminated when the child reaches 18 or the mother remarries. The average monthly amount as of June 30, 1953, was \$33.21, an appreciable increase over the \$28.65 average as of June 30, 1952.

Parent's Annuity. As in the Federal Old-Age and Survivors system, benefits to parents represent an insignificant fraction of the total number of awards. Through June 1953 a cumulative total of only 1674 had been awarded, nearly one-half of them when the

benefit first became payable. In the fiscal year 1951-1952, only 129 were awarded. As of June 30, 1953, there were 1083 in current-payment status and the average monthly amount was \$41.85, a sizable increase over the \$35.57 average at the end of the preceding year.

Lump-Sum Payments. Residual lump-sum payments, covering cases in which at death the total amount received in monthly benefits by the employee and his dependents and later by his survivors is less than the total amount of taxes paid by the employee, accumulated at interest, have been a feature of the railroad system since its inception. The need for this guarantee is strongly felt by railroad workers. A cumulative total of 185,167 residual lump-sum awards, totaling somewhat more than \$70 million, had been made by the end of June 1953. Mostly these have been for deaths before retirement began. The number awarded annually fluctuates considerably. For 1952-1953 7602 were awarded, and the average payment was \$922, a 16 percent increase over the \$789 for the preceding year.

Insurance lump-sum benefits payable when there is no survivor entitled to a monthly benefit for the month in which the employee died were introduced in 1947. This may be regarded as a funeral benefit. The amount is 10 times the deceased employee's basic amount. A cumulative total of 131,005 had been awarded at the end of June 1953. During the fiscal year ending in 1953 a total of 20,200 were awarded; the average amount paid was \$428, an increase of 21 percent over the \$354 average for the preceding year. It will be noted that the average sum paid under the railroad system considerably exceeds the maximum amount possible under the Federal Old-Age and Survivors Insurance system.

Benefit Comparison. The benefit structures of the Railroad Retirement and the Federal Old-Age and Survivors Insurance systems are basically alike. But the average monthly amounts payable under the railroad system are higher—in some instances appreciably so. In making comparisons of the two systems, however, it must always be borne in mind that the combined tax rate for the railroad system is much higher than the combined rate for the general Federal system, much higher even than the combined maximum ultimately expected under the latter system. It is this higher combined rate that makes possible the more liberal benefits under the railroad system. The average benefit amounts which follow are for benefits in current-payment status at the end of December 1952.

Benefit	Railroad System	FOASI
Old-age	\$95.49	\$49.25
Aged wife's	36.46	26.01
Child's	32.05	31.30
Widow's	42.58	40.67
Mother's	49.78	36.13
Parent's	40.44	41.43

The most striking differences are in the old-age, the wife's, and the mother's benefits, the amounts paid by the railroad system being appreciably higher than those under the Federal Old-Age and Survivors Insurance system. Children, widows, and parents fared about the same in both systems. The average lump-sum death benefit under the railroad system was \$431, whereas for the Federal system it was only \$178.20. It will be recalled that in addition to this funeral benefit the railroad workers are guaranteed a residual lump-sum payment in cases in which the total amount received in monthly benefits is less than the employee's taxes accumulated at interest. The railroad system also has a disability benefit.

Appeals. Claims for benefits, and other issues as well, are determined in the first instance by officials of the Bureau of Retirement Claims, and in nearly all cases their decisions are accepted. Bureau officials may reopen a case when additional evidence is discovered or obtained, or on further consideration of existing information they may change an original decision. But these decisions are not necessarily final. Persons who consider themselves aggrieved may take their cases to the Appeals Council. Decisions made by the Council may in turn be appealed to the Board itself. Relatively few appeals have been taken to date.

For the 16 years ending in June 1952, a cumulative total of 4612 Bureau decisions were passed upon by the Appeals Council.¹⁰ In recent years the number of appeals taken has decreased appreciably. Those taken have involved questions of eligibility for benefits, the benefit amount awarded, and employer coverage. The decisions rendered by the Council in these cases may be taken to indicate that the Bureau of Retirement Claims has administered the law faithfully and with a minimum of errors. In 92 percent of the cases, the decision made by the Bureau was sustained by the Council. In only 8 percent was the Bureau's decision reversed.

Relatively few cases are taken from the Appeals Council to the

¹⁰ *Annual Reports of the Railroad Retirement Board.*

Railroad Retirement Board itself for final administrative review. Through June 1952, a cumulative total of only 594 decisions on appeals were rendered by the Board; this was approximately one-tenth the number disposed of by the Council. In 93.6 percent of the appeals, the Board sustained the decision of the Bureau.

The machinery for resolving disputes involving administration of the Retirement Act by the Bureau, the Appeals Council, and the Board has proved so satisfactory to all concerned that few cases are appealed to the courts.

FINANCIAL ASPECTS

Although the Railroad Retirement Act authorizes Congress to appropriate as much money as is needed to meet all obligations, the system is self-supporting and is intended to be so.

Receipts and Expenditures. Payroll taxes levied on employers and employees are collected by the Bureau of Internal Revenue. Amounts due for the first two months of each calendar quarter must be paid by the 15th of the following month and for the third month by the end of the next month. These sums are first placed in the Treasury's General Fund. The Secretary of the Treasury is authorized to transfer the taxes as they are collected to the Railroad Retirement account. Benefit payments are made from the funds thus transferred. Congress does, however, specify the maximum amount of money that may be used for administrative expenses, and it appropriates enough money to meet the cost of crediting military service. Any excess of taxes collected and appropriations over benefits paid and administrative expenses is invested in special Treasury notes bearing 3 percent interest. This constitutes the system's reserve.

Table 22 shows receipts, expenditures, and balances in the retirement account by fiscal years since the system has been in operation. The cumulative total of taxes collected through June 1953 is \$5720.0 million, with interest amounting to \$476.9 million. Benefit payments made during this period amounted to \$3,273.5 million, and administrative expenses to \$63.1 million.

Tax collections have generally increased, to some extent as employment and wage rates increased, but also as the contribution rates went up. They are likely to level off in the future, and to fluctuate with changes in the general level of business activity, unless

TABLE 22. Railroad Retirement System: Receipts, Expenditures, and Balance in the Retirement Account, by Fiscal Year, 1935-1953
(In Millions)

Fiscal Year	Receipts		Expenditures		Balance at End of Period
	Taxes	Interest	Benefits	Adminis- tration	
Through June 1938	\$150 5	\$ 1 4	\$ 87 2	\$4 7	\$ 60 7
1938-39	109.3	2 2	107 1	2 9	74 1
1939-40	121.0	2 3	114 0	2 8	82.5
1940-41	136 9	2 5	121.8	2 9	76 8
1941-42	170 0	3 1	126 7	2 9	94 1
1942-43	208 8	5 8	130.9	2 8	183 9
1943-44	267 1	9 8	135 2	2 4	321.2
1944-45	285 0	15 2	142 5	2 4	502 7
1945-46	282 6	19 9	153 8	2 7	660.9
1946-47	380.1	24 2	173.1	4 7	810 3
1947-48	557 1	38 9	224 9	5 0	1382 7
1948-49	563.8	50 9	283.1	4 9	1725.1
1949-50	550 2	62 2	301 5	4 9	2063 7
1950-51	577.5	70 2	317.1	4 7	2420.0
1951-52	735.0	78 9	394 2	6 3	2869 0
1952-53	625.2	89 3	460.4	6.1	3147 0

contribution rates are again increased or the taxable base is raised. The large sum reported for 1951-1952 represents collections for 14 months, this resulted because the quarterly basis for collecting taxes was abandoned and a monthly system adopted. Had the old system been used, total taxes for 1951-1952 would have been about \$627.0 million. Benefit expenditures have steadily increased as accrued liabilities matured. The marked increase beginning in 1947-1948 reflects survivor benefits which became payable then. Subsequent increases in benefit amounts and the spouse's benefit introduced in 1951 have made for still larger outlays. Benefit payments will continue to increase as more accrued liabilities mature. There has been a steady increase in the size of the reserve, to \$3147.0 million on June 30, 1953. This reserve will continue to grow until expenditures exceed income, which as things now stand will be in the near future unless the tax rates are raised.

Actuarial Aspects. The Railroad Retirement Act requires that at least once every three years the liabilities incurred by the system

shall be estimated and compared with the resources for meeting them. This is done in order to determine whether the rates charged, together with the resources of the Trust Fund, will be adequate to cover the accrued liabilities as they mature in the future. The fifth actuarial valuation of assets and liabilities was made as of December 31, 1950, but the actuaries also took into consideration the amendments of 1951 and 1952.¹¹

The problem of estimating the tax rates needed to finance the system over a long period of years is not simple, especially in troubled times such as we have experienced in recent decades and will no doubt continue to experience in the future. Assumptions must be made regarding future trends in such matters as employee withdrawal rates, number of dependents, retirement and death rates, and wage and salary levels. These assumptions may be too conservative or not conservative enough. Amendments to the law, usually liberalizing benefit amounts or conditions of eligibility, further complicate the problem of planning for a balance between accruing liabilities and anticipated income. The actual trends in these and other matters that vitally affect actuarial soundness become known only as time passes.

The test of actuarial soundness usually applied to governmental systems of this kind is whether future income from contribution rates and interest will provide the amount of money necessary to meet all obligations as they arise. The function of the trust fund, or reserve, is to serve as a capital sum that yields interest. Contribution rates must make up the difference.

It is impossible at any given time to tell by means of this test whether a system's finances will be sound at any future date if that date is an extended one. This is so because it is impossible to know in advance whether the basic assumptions regarding future trends will be realized. Nevertheless, estimates are necessary and useful, and are made periodically.

The Railroad Retirement system has had an unamortized liability since its inception. Contribution rates and interest on the Trust Fund have never been considered adequate to meet the estimated liabilities of the future. In the first years a deficit was inevitable because large numbers of older workers became eligible for benefits and their contributions could not possibly finance those benefits.

¹¹ *Annual Report of the Railroad Retirement Board, 1952-1953*, Appendix A, pp. 129-216.

Thus the system started with a large accrued liability. However, the size of this unamortized liability has increased steadily. It rose from \$3.4 billion in 1938, to \$5.5 billion in 1941, to \$7.4 billion in 1947, and to an estimated \$14.6 billion in 1951. The marked increase for 1951 over 1947 resulted largely from the benefit liberalizations introduced by the amendments of that year; this figure allows also for a further small increase in benefits in 1952. As of 1953, the system's unfunded liability was increasing somewhat more than \$45 million a year.

The maximum combined contribution rate required to bring assets and liabilities into balance was estimated in 1951 at 13.41 percent, of which 0.15 was for administrative expenses. This compares with the required rate of 12.72 percent reported for the 1947 valuation. The maximum combined rate under the law as it stands is 12.5 percent, and this became effective in 1952. Rates were not raised when the benefits were liberalized in 1951. The deficit is therefore approximately 0.9 percent of taxable pay rolls. This relatively small difference in rates was achieved by making substantial, and quite probably justifiable, changes in basic assumptions compared with those used in the previous valuation. Transfer to the Old-Age and Survivors Insurance system of employees with less than 10 years of railroad service was also a factor of importance, since this reduced the railroad system's liability.

The fact that there is a really substantial burden of unamortized liability does not mean that the railroad system is in serious danger or even that major changes must be made in the benefit structure. It is not clear how the deficit is to be made up, assuming that it will be made up. Favorable economic conditions, including low retirement rates, could reduce its size appreciably. At this time the Congress intends for the system to pay its own way. It is not likely that benefits will be reduced; it is more probable that further liberalization will take place. Rate increases appear to be the only practicable way out. However, the rate is already high, and pressure against further increases may well develop, especially if economic conditions are not favorable.

CHAPTER EIGHT

FEDERAL CIVIL SERVICE RETIREMENT SYSTEMS

THE Federal government has always been faced with the problem of competing for its personnel with private concerns which in many instances pay higher salaries and offer more rapid promotion. One of the ways in which that competition has in part been met is by the introduction and refinement of retirement systems. But because of the spoils system which preceded the Civil Service Act, public hostility or unfriendliness to government employees, the relatively small number of Federal employees until recently, and the absence of widespread pension plans in private industry, the system was slow to materialize.¹

THE U.S. CIVIL SERVICE RETIREMENT ACT

Several separate acts make up an uncoordinated Federal retirement system. The principal one of these, which includes most Federal employees, is known as the Civil Service Retirement Act. This law was enacted on May 22, 1920, and has been improved and liberalized numerous times through amendments.

Coverage. The Act, as amended, applies to all officers and employees in or under the executive, legislative, and judicial branches, including employees of government-owned corporations and heads of all departments, independent establishments, and agencies in the executive branch, except employees excluded from coverage by executive order and those subject to another public retirement system. It also covers District of Columbia officers and employees not subject to another retirement system, and citizen employees of the Panama Canal, the Panama Railroad, and the Alaska Railroad.

¹ U.S. Civil Service Commission, *History of the Federal Civil Service, 1789 to the Present*, Washington, 1941.

It does not cover elective officers in the executive branch of the government. Certain elective officers and employees in the legislative branch are not compulsorily covered, but they are given the privilege of voluntarily electing to come under the Act provided they do so in writing within six months after appointment or after taking the oath of office. The Act does not apply to temporary and intermittent employees of the House and Senate, and the Architect of the Capitol may exclude any of his employees whose tenure is temporary or of uncertain duration. The President may exclude any officer, employee, or group in the executive branch whose tenure of office or employment is intermittent or of uncertain duration.

An Executive Order excludes persons who are employed for one year or less, those whose employment is periodic, part-time, or recurrent and for whom regular tours of duty are not contemplated, employees and consultants paid on a contract or fee basis, piece workers not serving under regular or permanent appointments, those serving without pay or for a nominal fee of \$12 or less per year, cooperative employees not wholly under the control of the Federal government and who are not otherwise subject to the Retirement Act, intermittent alien employees working outside the continental limits, member and patient employees in Government hospitals or homes, temporary employees whose eligibility for permanent or indefinite appointments is being determined, acting postmasters, clerks in fourth-class post offices, substitute rural carriers, special-delivery messengers at second, third, and fourth-class post offices, and some others.

Retirement. The compulsory retirement age is 70, provided at least 15 years of creditable government service have been completed. This rule applies to the vast majority of Federal workers. An employee who reaches the compulsory retirement age before serving the 15 years may be continued in Federal employment until he completes that period of service. The President may by executive order continue any employee beyond the compulsory retirement age even though the 15-year minimum requirement has been served, when in his judgment the public interest so requires. An amendment to the Act approved February 28, 1948, took from the employing agency its previously existing right to request the retirement of an employee where it felt that the employee was disqualified to render satisfactory and efficient service.

Persons receiving an annuity and who have reached the age of 60 may not again be eligible to appointment unless the appointing

authority determines that they have special qualifications. If such a person is reappointed immediately following retirement or later, the annuity is not reduced or discontinued, nor are retirement contributions collected from him during his period of reemployment, but an amount equal to the annuity he is receiving is deducted from his pay while he is so employed. The period of service under such reemployment is not creditable for retirement purposes.

Employment outside the Government will not affect an annuitant's right to receive his annuity, except possibly in the case of a disability annuitant.

Methods of Computing Annuities. There are two simple formulas used in computing the annuities. One is to allow 1.5 percent of the average annual basic pay for any five consecutive years of service, when such average is \$5000 or more, multiplied by the total number of years of creditable service. The other, used when the pay average is less than \$5000, is to allow 1 percent of that average basic pay, add \$25 to that, and multiply by the total years of creditable service. However, no annuity may exceed an amount equal to 80 percent of the highest average annual five-consecutive-year pay received. This will affect only low-salaried employees with long service. The 80 percent limitation does not apply to the extra annuity which employees may purchase by making voluntary contributions.

Retirement Annuities.

Age and Optional Annuities. Those retired at age 70 who have fulfilled all of the requirements receive age annuities. There is, however, provision for retirement with an annuity before age 70. Anyone 60 years old who has had at least 30 years of service, or anyone 62 years old with at least 15 years of service, has the option of retiring with an annuity. This is a matter of personal choice. An employee with at least 30 years of service may retire upon reaching age 55, or later, but he will receive an annuity reduced by one-fourth of 1 percent for each month he is under age 60.

Discontinued Service Annuities. Any person with 25 or more years of service who becomes separated through no fault of his own and not for cause on charges of misconduct or delinquency may receive an immediate annuity reduced by one-fourth of 1 percent for each full month he is under age 60 at the date of separation.

Any person who has at least five years but less than 20 years of creditable civilian service and who, before he is eligible for retire-

ment, becomes absolutely separated from the government service may elect to receive either: (1) a deferred annuity computed as described above, beginning at age 62, or (2) a refund of the total amount he has paid in plus interest at 4 percent before 1948 and at 3 percent thereafter. An election to receive a deferred annuity may be changed at any time after withdrawal and before age 62.

Joint-and-Survivor Options at Retirement. There are two ways in which annuitants may share their retirement income with certain survivors. These are cases where the retired person accepts a reduced annuity during his lifetime and at his death someone else receives an annuity. Such arrangements are optional with the employees at the time of retirement

Under what is sometimes called option 1, any married employee may elect to receive an annuity reduced by 5 percent of the first \$1500 and 10 percent of the amount above that and a further reduction of three-fourths of 1 percent for each full year the spouse is under age 60, but the total reduction is in no case to exceed 25 percent of the full annuity. After the insured's death, the surviving spouse will receive an annuity equal to 50 percent of the full annuity. The spouse's annuity will begin upon attainment of age 50 if younger than that when the insured dies, or upon the insured's death if the spouse is 50 or older, and it will continue until remarriage or death. Should the spouse die before the insured, no change in the election will be permitted; nor will the size of the annuity be increased. This option is available under any plan except that for discontinued service after five or more years of civilian service.

Under option 2, any unmarried employee, male or female, who is eligible to an age, optional, or 25-year-service retirement annuity, may elect to designate as a survivor-annuitant anyone who has an "insurable interest" in him, i.e., anyone who would suffer a financial loss in the event of his death. An insurable interest is presumed in case of persons of near relationship. If this option is chosen, the employee's annuity will be reduced. If the designated survivor is as old or older than the annuitant or less than five years younger, the annuity is reduced to 90 percent. If the designated survivor is more than five years younger, then the annuity is further reduced by 5 percent for each five additional years the survivor is younger, down to 70 percent if the survivor is 20 but less than 25 years younger, and to 60 percent if 25 or more years younger. The survivor's annuity is 50 percent of the reduced, not the full, annuity. Furthermore, the

election may not be made unless the employee at retirement takes a physical examination and is found to be in good health.

These reduced employee annuities are not established on a strictly actuarial basis and in most instances are more favorable to the annuitant. For married men the bargain is usually from 10 to 30 percent, but in some instances is 80 percent. For unmarried employees the advantage is considerably less. And in both cases there will be not a few instances in which the annuity is lower than would be yielded if computed on a strictly actuarial basis.

A Retroactive Provision. The Act was amended in 1948 to authorize an increase in the annuities of persons already retired, of 25 percent or \$300, whichever was less. But each married annuitant who elected to forgo the increase before the amendment became effective would thereby enable the spouse, on the annuitant's death, to receive an annuity equal to one-half that of the retired employee, but not in any case to exceed \$600 a year. In 1950 a further amendment was passed restoring the full increase and allowing the spouse's annuity as well.

Disability Annuities. Provision is made for the retirement of disabled employees. Any employee subject to the Retirement Act who has served as a civilian for not less than five years and who, before he meets the age and service requirements for regular retirement, becomes totally disabled for "useful and efficient service in the grade or class of position occupied" or in any other position of the same grade or class, may be retired on an immediate annuity regardless of age. However, the disability must be the result of disease or injury "not due to vicious habits, intemperance, or willful misconduct" on the part of the disabled employee. Proof that the employee was free from these defects for the five years immediately preceding disability may be required. Retirement may be at the request of the disabled employee or at the request of the head of his department or agency. But no one shall be so retired unless examined and found disabled by a physician or board of physicians designated by the Civil Service Commission. Application must be made before separation, or within one year after separation from the service unless the person is hospitalized or disabled because of mental incompetence.

The amount of a disability annuity payable is determined in the same manner as for other retirement annuities. Unless the disability is permanent, annual physical examinations by approved physicians

are generally required until age 60 is reached, and special examinations may be ordered at any time. Failure to appear for the examination will result in the suspension of the annuity until continuance of the disability can be satisfactorily established.

If there is recovery before age 60 sufficient to permit appointment to an appropriate position fairly comparable to the one occupied at the time of retirement, the annuity will be continued temporarily, but not to exceed one year, in order to enable the employee to locate any appropriate available position. If such a position cannot be found, the disability annuity is discontinued and he then becomes eligible for a deferred annuity beginning at age 62.

A person receiving payments under the Federal Employees' Compensation Act, which covers occupational disabilities, may not also receive an annuity covering the same period of time, but the injured employee may choose the higher of the two payments. However, a widow receiving a civil service annuity on her own account as an employee may also concurrently receive payments under the Employees' Compensation Act on account of the death of her husband. Where a lump sum has been awarded under the compensation law and a disability annuity has been paid or becomes payable on account of that same disability, the amount of the lump-sum payment attributable to the period for which the annuity is payable must be refunded to the compensation fund.

Special Annuities. Provision is made in the Civil Service Retirement Act for special treatment to two groups of persons.

Members of Congress. In August of 1946, provision was made for the inclusion of members of Congress in the Civil Service Retirement system. Senators, Representatives, Delegates from the Territories, and the Resident Commissioner from Puerto Rico may come under the Act if they apply in writing within six months after the date on which they take the oath of office in their respective positions, or, for those then in office, six months after August 2, 1946. These different officers will all hereafter be referred to as Congressmen.

In order to be eligible for an annuity, a Congressman must have served at least six years, must be at least 62 years old, and must no longer be holding office. But in case disability occurs while in office after five years of service have been rendered, one may retire with an annuity irrespective of age.

The nonforfeiture life annuity consists of an amount equal to 2.5

percent of the average basic pay as a Congressman multiplied by the years served as a member. However, it is not to exceed three-fourths of the salary being received at the time of separation or retirement from office. Congressmen may elect to receive a higher forfeitable annuity or a lower joint-and-survivor annuity.

The annuity must be paid for with contributions based on annual basic pay, and no Congressman is eligible for an annuity unless he has made such contributions covering the last five years or more of service. A member may deposit payments on the salary of previous years served, plus interest at 4 percent for service before 1948 and 3 percent thereafter, compounded annually, and in this way provide for a higher annuity. For service between August 1, 1920, and June 30, 1926, 2.5 percent of basic pay must be deposited; 3.5 percent for service between July 1, 1926, and June 30, 1942; 5 percent for service between July 1, 1942, and August 1, 1946. These are the same contribution rates that have been paid by other covered employees during these same years. The rate has been 6 percent for service from August 2, 1946.

Congressmen who are separated before six years of service and who are not retired for disability will be refunded the amount they have contributed or deposited, accumulated at interest. Should they later be reelected or appointed to Congress, they will not be eligible to an annuity based on the prior service unless they redeposit the refunds, but interest will not be charged for periods of separation from service. A former Congressman receiving an annuity and who is later reelected or appointed to office will have his annuity suspended while he is in office, but he may pay the specified contributions and the time served may be counted on the annuity he will receive when he again retires.

A person receiving a Congressional annuity may also receive an annuity under the regular retirement system, but if he has had at least six years in Congress and some of it has been since 1946, the time spent in Congress will not be counted on the regular annuity.

Persons Dealing with Criminals. Any person covered by the Retirement Act whose duties are "primarily the investigation, apprehension, or detention of persons suspected or convicted of offenses against the criminal laws of the United States," including those promoted to supervisory or administrative positions, may retire with an annuity if he is at least 50 years of age and has had at least 20 years of service in performing those duties, provided the Civil Service

Commission approves. The annuity paid to such a person is an amount equal to 2 percent of the average pay for any five consecutive years preceding the date of retirement, multiplied by years of service not in excess of 30. Contributions are at the rates prescribed by the Civil Service Retirement Act as amended.

The Civil Service Commission shall, upon the recommendation of a department or agency involved, determine whether an officer or employee is entitled to an annuity under this provision of the law. In making its determination, the Commission considers the degree of hazard involved in the duties performed, rather than the general duties of the class of position held.

Benefits to Widows and Children. Until 1948, there were no survivor annuities like those provided in the Federal Old-Age and Survivors Insurance system or in the Railroad Retirement system. Benefits for widows and children were provided by the 1948 amendment. But the pattern established differs appreciably from that in the Federal Old-Age and Survivors system.

Eligibility. The benefits provided for widows and children are payable only if the employee involved has died and only if that employee had completed five full years of creditable civilian service at the time of his death.

In order to be eligible, a widow must have been married to the deceased for at least two years immediately preceding his death, or she must have borne him a child during the marriage. A child, including a dependent stepchild or an adopted child, to be eligible, must be unmarried, and must be under the age of 18 or incapable of self-support by reason of physical or mental disability.

In the Retirement Act, some distinctions are made as between the widows and children of employees who die while in active service and those of persons who die after they become annuitants.

Deceased Employees If a married man dies while in active service leaving a widow but no child eligible for a child's benefit, the surviving widow will receive an annuity equal to 50 percent of the employee's basic annuity, computed on the basis of his salary and service at the time of his death. If at the time of his death she is at least 50 years old, the annuity is payable immediately. If she is under 50, it becomes payable when she attains age 50. It is payable until her death or remarriage.

If the deceased employee is survived by a widow and also by a child entitled to a child's benefit, then the widow is entitled to the

annuity immediately, irrespective of her age at the time of his death. This annuity continues until age 50, even if she should no longer have in her care a child entitled to a child's benefit. At age 50, she becomes entitled to a regular widow's benefit, of the same amount, if she has not in the meantime remarried.

If the deceased employee leaves a widow and a child or children, each child will receive an immediate annuity, the size of which will be the least of the following amounts: (1) 25 percent of the father's basic annuity; (2) \$360; (3) \$900 divided by the number of eligible children. This means a maximum of \$30 per month for one child and \$75 per month for all children combined. The widow also receives an annuity of 50 percent of his basic annuity.

Should a deceased employee, male or female, leave a child or children eligible for a child's benefit, but leave no spouse, the child's annuity is larger. Each child will receive the least of the following amounts: (1) 50 percent of the parent's basic annuity; (2) \$480; (3) \$1200 divided by the number of eligible children. This means a maximum of \$40 per month for one child and \$100 a month for all children combined.

In each of these cases, if one of the annuities is terminated, as would be the case if a widow remarried or a child became 18, then the children's benefits would be recomputed to allow a higher payment if one is possible.

Deceased Annuitants Certain annuities accrue to survivors in case of the death of annuitants, except for those receiving annuities for discontinued service after five or more years of service.

If any annuitant dies and leaves a widow but no child entitled to a child's annuity, the widow does not receive an annuity unless she was designated as a survivor-annuitant by her husband at the time of his retirement. In this case he would have received a reduced annuity and at his death she would receive 50 percent of his basic annuity beginning at age 50 and continuing until remarriage or death.

But where the annuitant leaves both a widow and a child entitled to a child's annuity, the same widow's benefit is paid as in the case of a deceased male employee. The widow's annuity will be 50 percent of his basic annuity.

If the deceased annuitant leaves a widow with eligible children, each child receives the least of the following: (1) 50 percent of the

widow's annuity—not that of the annuitant; (2) \$360; (3) \$900 divided by the number of eligible children

Should the deceased annuitant leave no widow or widower, but leave a surviving child or children entitled to an annuity, each child gets the least of the following: (1) 50 percent of the deceased's annuity; (2) \$480; (3) \$1200 divided by the number of eligible children.

Accrual of Annuities. The annuities provided by this Act are now accrued on a monthly basis, rather than on a daily basis as formerly was done. When the right to an annuity terminates, no annuity is payable for the month in which the termination occurs or for any portion of that month. But an annuity for a full month which is due but which has not yet been paid will be paid after termination.

Refunds. Unlike the Federal Old-Age and Survivors Insurance system, the Civil Service Retirement Act guarantees a return of the amounts that insured persons have themselves contributed, accumulated at interest. These payments are accumulated, unused, non-forfeited savings and are truly refunds rather than benefits.

Separation with Less than 20 Years of Service. Any person who is absolutely separated from a Federal position under the Retirement Act before completing 20 years of civilian service and before becoming eligible for certain retirement is entitled to a refund of the entire amount credited to his account, with interest at 4 percent for service before 1948 and at 3 percent for service thereafter to the date of separation. If he had more than five years of civilian service, he may leave his contributions and elect an annuity beginning at age 62. If he has had 20 or more years of service, he is not entitled to a refund, but he is entitled to an annuity at age 62. Interest is not paid when the period of employment is one year or less. Military service is not counted until five years of civilian service have been completed. Should the separated employee later be appointed to a position under the Retirement Act, he must redeposit the amount refunded, with interest, if he wishes to count the prior service toward an annuity.

Death Without Survivors. Should an employee in the retirement system die leaving no widow or children entitled to an immediate or future annuity, or the rights of such survivors terminate before a valid claim is established, the total amount of his contributions, plus interest, is paid in a lump sum to his designated beneficiary or

estate. Should an annuitant die without leaving anyone eligible to a survivor's annuity, or if his eligible survivor's right to an annuity terminates before a valid claim has been established, his accumulated contributions at interest less the total amount of annuity paid to the retired employee are paid in a lump sum.

Unused Accumulated Savings. If for any reason the annuities received by the survivors are terminated before the amount received by the survivors and the employee equals the insured person's contributions accumulated at interest to the date of his death or retirement, then the difference is refunded.

Legal Processes. Annuity and refund payments are not subject to attachment, levy, garnishment, or other legal process except for indebtedness due to the United States. Overpayments of annuities made to an annuitant are not recovered where the recipient is without fault, when in the judgment of the Civil Service Commission such recovery would be "contrary to equity and good conscience." Until the income received equals the amount contributed, only 3 percent must be reported as income subject to the Federal income tax; thereafter, all of the income must be so reported.

Allowable Service

Civilian Service. All employment in the civil service of the United States and in the District of Columbia, beginning with the date of original employment, is counted, whether in a classified or unclassified position, whether continuous or broken, and whether in one or more departments, branches, or independent offices, or in the legislative or judicial branches. Periods of civilian service overseas when performed under the authority of the United States are also counted.

Employees who are brought within the scope of the Act are credited with all past service, but they may pay the amount of contributions that they would have paid covering civilian service since August 1, 1920, had they been included in the system throughout their career, plus 4 percent interest for the time served before January 1, 1948, and 3 percent for time served thereafter. The necessary amount may be paid in installments, with minimum payment of \$10. The employee may elect to have service since August 1920 counted even without making the payment, but if he does so his annuity will be reduced by 10 percent of the amount of the indicated deposit. No deposit is required for service prior to August 1, 1920, or for any periods of honorable military service.

Military Furlough. Some employees covered by the Retirement Act were separated from civilian rolls because they entered military service, and their retirement coverage under the law was therefore terminated. Others went on leave or were furloughed for military service. Some of these would have become eligible during their military service to optional or age retirement, while others became totally disabled. Some of those disabled could not be restored to their jobs. They could have taken discontinued service benefits, but those were considerably lower than optional, age, or disability annuities.

The retirement law was therefore amended to preserve the continuity of their retirement rights while in service, and they were thus enabled to retire with whatever type of benefit they had established title to, without the necessity of first returning to their government jobs. They were allowed civilian service credit of six months per calendar year for military furlough, and were permitted to acquire full credit if they made a service-credit deposit in the fund based on their military pay.

This was changed in December of 1945 to give them full civilian service credit for the military furlough period without the necessity of making a deposit. That is to say, for retirement purposes, no person who left his job to enter the armed forces during a period of war or national emergency was considered as having been separated.

By an amendment made in February of 1948, free credit was allowed for the military service as such and the time spent in military service is now counted as though it were spent in civilian government service. The basic pay received in military service may be counted if it will increase the five-year average salary used as a basis for computing annuities.

Furthermore, if a person is receiving retired military pay on account of a service-connected disability, incurred in combat with an enemy or resulting from the explosion of an instrument of war, or if he is receiving retired pay under the act of June 29, 1948, which provides for retired pay after a minimum of 20 years of military service, then all of the military service is counted under the Civil Service Retirement Act. Thus some military service may be counted for Civil Service retirement and for military retired pay.

Examples of Annuities. Table 23 gives examples of annuities for assumed wages and years of service. Since annuities are payable

in 12 equal monthly installments computed to the nearest whole dollar, the actual amounts received will in some cases be slightly higher, and in others slightly lower, than the figures given in the table.

Contributions. The system is contributory. Deductions from employees' pay began at 2.5 percent, were raised to 3.5 percent on July 1, 1926, to 5 percent on July 1, 1942, and to 6 percent on July 1, 1948, levied on the wage or salary, excluding bonus and overtime pay. Where under previous service deductions should have been made but through error or misunderstanding were not, the amount involved must be deposited or it will be withheld from the annuity payable on retirement. Sums collected are credited to the employees' individual accounts.

Employees are permitted to make voluntary contributions in multiples of \$25, but not to exceed 10 percent of annual basic pay for service since August 1, 1920, and these are accumulated at 3 percent interest compounded annually and used to augment the retirement annuity. The life annuity so purchased consists of \$7 for each \$100 in the individual's voluntary contribution account, plus 20 cents for each full year the person is over 55 years old at retirement. In case of the employee's death, the amount contributed plus

TABLE 23. Examples of Annuities Provided by the United States Civil Service Retirement Act Under the Basic Formula When All Payments Have Been Made ²

Highest 5-Year Average Salary	Years of Creditable Service						
	5	10	15	20	25	30	35
\$ 1,500	\$200	\$ 400	\$ 600	\$ 800	\$1000	\$1200	\$1200
2,000	225	450	675	900	1125	1350	1575
2,500	250	500	750	1000	1250	1500	1750
3,500	300	600	900	1200	1500	1800	2100
4,000	325	650	975	1300	1625	1950	2275
5,000	375	750	1125	1500	1875	2250	2625
7,500	563	1125	1688	2250	2813	3375	3938
10,000	750	1500	2250	3000	3750	4500	5250

² Lyman L. Woodman, *Recent Changes in the Federal Civil Service Retirement System*, U.S. Civil Service Commission, Washington, 1948, p. 13. Other examples are given by Robert J. Myers, Actuarial Consultant, Social Security Administration, in "Recent Amendments to the Civil Service Retirement Act," *Social Security Bulletin*, April 1948, pp. 9-17.

interest is payable to the designated beneficiary in a lump sum. Voluntary contributions plus interest may be withdrawn from the fund if the employee is separated from the service before retirement.

Individual retirement records are maintained by the department or agency in which a person is employed, and the amounts deducted are credited to the "civil-service retirement and disability fund" created for the purpose. The money is deposited with the Treasury of the United States and is appropriated to pay the annuities, refunds, and benefits provided in the Act. The Treasury invests amounts not needed for current payments in United States Government bonds.

Administration. The Act is administered by the U.S. Civil Service Commission, which also administers certain other retirement acts. A three-man Board of Actuaries, one of whom is the Government actuary, reports annually on the operations of the Act, and recommends such changes as it may deem necessary. The Board makes a valuation of the retirement and disability fund at five-year intervals, or oftener if it is considered necessary. The 1945 valuation was not made because of the war.

All rules and regulations necessary and proper for the Act's administration are made by the Civil Service Commission. Appeal to the Commissioners is permitted from any final action or order made by the Retirement Division.

Operations. The Act has been in operation since August 1920 and a considerable volume of experience has been accumulated. A brief summary of that experience will now be undertaken. The experience to date has been for the most part with employee annuitants, but the more limited experience with recently established survivor benefits will also be reviewed.

Coverage. The system began in 1920 with a membership of about 300,000. At that time it was limited primarily to employees in the classified civil service. Successive coverage amendments and growth in the number of employees in Federal service have greatly increased the number covered. Today there are approximately 2 million legislative, judicial, and executive employees covered, or approximately 80 percent of all paid Federal civilian employees.

Employee Annuitants. Table 24 shows the slow but steady growth in the number of employee annuitants on the retirement roll. The total number rose from 6471 in 1921 to 176,330 at the end of

TABLE 24. Civil Service Retirement System Number and Type of Employee Annuitants, by Year ³

Fiscal Year Ended June 30	Total on Roll	Age	Disability	Separation	
				Voluntary	Involuntary
1921	6,471	5,947	524		.
1922	7,576	6,667	909		. .
1923	9,334	7,994	1,340		. . .
1924	10,548	8,895	1 653		. . .
1925	11,689	9,741	1,948		. . .
1926	12,524	10,277	2,247		.
1927	14,119	11,353	2,766		
1928	15,383	12,173	3,210		
1929	16,501	12,924	3,577		
1930	17,768	12,504	3,994		1,270
1931	22,650	15,357	4,947	972	1,374
1932	25,567	16,600	5,973	1,590	1,404
1933	32,835	21,613	7,281	2,402	1,539
1934	44,708	22,969	8,941	3,944	8,854
1935	48,665	23,863	9,886	4,310	10,606
1936	51,206	24,603	10,877	4,610	11,116
1937	53,306	25,391	12,044	4,961	10,910
1938	56,130	26,670	13,340	5,401	10,719
1939	58,385	27,709	14,315	5,896	10,465
1940	62,027	30,216	15,294	6,318	10,199
1941	66,092	32,508	16,768	6,870	9,946
1942	69,123	33,279	18,032	8,171	9,641
1943	73,880	31,903	19,602	12,660	9,563
1944	78,206	30,262	21,158	17,240	9,546
1945	85,011	28,904	23,389	23,100	9,618
1946	95,888	28,524	26,827	29,377	11,160
1947	111,045	27,929	31,502	34 443	17,171
1948	124,962	27,458	35,353	39,661	22,490
1949	138,907	27,512	39,076	47,601	24,718
1950	155,135	27,489	42,869	47,771	29,565
1951	166,680	27,373	45,601	63,158	30,548
1952	176,330	27,254	47,964	70,326	30,786

³ Civil Service Commission Retirement Reports

June 1952. The total number on the roll increased appreciably in 1934 when a substantial number of civil servants were involuntarily separated because of the depression. Marked increases occurred also at the end of the Second World War when large numbers retired voluntarily.

There was a very gradual increase in the number of those retired because of reaching the maximum age until 1943, when an equally gradual decline set in which has continued to date. Reductions in force primarily affected persons with the smallest amount of service and induced voluntary and forced involuntary separations in this category. Actually, the number listed as retired on the basis of age is deceptive. For substantial numbers of older people, ages 60 and 62 for example, with from 15 to 30 years of service, chose voluntarily to retire. In 1952 there were 52,504 of these two groups on the roll. Some others retired voluntarily at age 55 after 30 years of service, or at age 50 after 20 years of service.

The number of disability annuitants on the roll has increased every year, and at a more rapid rate than the increase in all annuitants. In 1921 disability annuitants constituted only 8 percent of the total number on the roll but they increased rapidly, reaching about 20 percent. Beginning in 1936 the percentage increased steadily from 20 to 28.3 in 1947 and then declined steadily because the roll became heavily weighted with separated annuitants. In 1952, disability annuitants constituted 27.2 percent of the total. The ratio of disability to maximum age annuitants is striking. It rose steadily from 8.8 percent in 1921 to 50 percent in 1938 and exceeded 100 percent in 1947. In 1952 it was slightly more than 175 percent.

Voluntary separation annuitants are of four kinds. those retiring with 30 years or more of service, those retiring with at least 15 but less than 30 years, those retiring with 5 but less than 15 years, and a special group—those whose work is the investigation, apprehension, and detention of criminals—who may retire at age 50 after 20 years of service. The 30-year group first appeared on the roll in 1931, the 15–29 group in 1942, the 5–14 group in 1943, and the special group in 1948. The 30-year group in 1952 constituted approximately 60 percent of all voluntary retirements; most of them had retired under the 60-year age option. Approximately one-half of the remainder had retired under the 15–29 year and age 62 provision. Involuntary separation annuitants are for the most part those who were forced out after from 5 to 15 years of service or those with 25 or 30 years of

service. The number of these annuitants has always been relatively small and in 1952 they constituted only 17.5 percent of the total number on the roll.

The first survivor annuitants, practically all of whom were women, appeared on the roll in 1941, and each year thereafter until the amendments of 1948 small numbers were added. By the end of the fiscal year 1948 there were only approximately 300. These were persons who received annuities because the deceased employee concerned, in nearly every case a husband, had chosen to accept a reduced annuity. Nearly three-fourths were under the option which allowed the survivor-annuitant one-half the insured person's annuity.

Survivors of deceased annuitants and employees appeared on the roll in sizable numbers only after the law was amended early in 1948 to provide benefits to widows, widowers, and children. It will be recalled that there was no wife's annuity. On June 30, 1948, the total number of survivor annuitants on the roll was only 935, and 357 of those were survivors of deceased employees. But the effect of the new survivor benefit amendment then made itself felt, and the total rose to 9429 by the end of the next fiscal year. By the end of June 1952 the total had increased to 39,902, of whom 21,047 were survivors of deceased employees and 9024 were children. Thus there were approximately 22.6 percent as many survivor as employee annuitants.

Payments. The average employee annuity has never been large. In 1921 it was \$568, then it declined steadily to \$545 in 1925, and increased again to \$759 in 1930. Thereafter it increased still more, but slowly. It was not until 1948 that the average employee annuity exceeded \$1000. Gradual increases since then brought the figure to \$1188 at the end of June 1952. Employees retired after the law was amended in 1948 received slightly more, the average for them being \$1385. They also contributed more—an average of \$2010 as compared with \$1400 for those retired before the 1948 amendments. Annuitants averaged 67.4 years of age in 1952, and they had on the average 23.6 years of service. Survivor annuities awarded prior to the liberalizations of 1948 averaged \$445, and those awarded after averaged \$931. For both combined, the average was \$582 in 1952.

A better idea of the size of annuities is presented in Table 25, in which annuitants are distributed by size of annuity. One-half of the employee annuitants received less than \$1200, and nearly 35 percent

received from \$1200 to \$1799. The remainder were getting \$1800 or more, but a total of only 55 were receiving \$6000 or over. Congressmen and employees dealing with criminals received the largest annuities. Survivor annuitants were mostly in the lowest bracket. More than two-thirds of them, 68.5 percent, received less than \$600, and almost one-half of those were getting less than \$230. The largest survivor annuities were in the \$2400 to \$5999 class, but there were only 43 recipients in that class.

TABLE 25. Civil Service Retirement System. Distribution of Annuitants by Size of Annuity, 1952 ⁴

Size of Annuity	Employee Annuitants		Survivor Annuitants	
	Number	Percent	Number	Percent
Under \$600	43,969	24.9	27,319	68.5
\$600 to \$1199	44,176	25.1	11,132	27.9
\$1200 to \$1799	61,306	34.8	1,208	3.0
\$1800 to \$2399	17,704	10.0	200	0.5
\$2400 to \$5999	9,120	5.2	43	
\$6000 and over	55	.		
Totals	176,330		39,902	

The total amount paid out to retired employees increased steadily each year, from \$9.6 million in 1921 to \$203.6 million in the fiscal year 1952, or a grand total of \$1865.1 million since the system began. Payments to survivors have been small, but they are increasing; in 1952 they amounted to \$16.1 million. Payments for death claims and refunds have been relatively small, they first reached substantial proportions at the end of World War II, when large numbers of short-time employees were separated from the service. Slightly more than 55 percent of the grand total of \$1 billion paid out in death claims and refunds during the first 31 years was paid in the years 1945-1948. Allowing for adjustments, total disbursements by the end of 1952 totaled slightly more than \$2.9 billion, two-thirds of it being paid out since 1945. For the fiscal year 1951-1952, disbursements amounted to \$298.6 million.

Receipts have consisted of salary deductions, voluntary contributions made by employees to increase their annuities, transfers from other retirement funds as employees were transferred, government

⁴ Adapted from *Civil Service Commission Retirement Report*, 1952, p. 18.

appropriations, and interest on the reserve. Currently the most important of these receipts consists of employee contributions, which in 1952 accounted for 45.3 percent of all receipts. Next in importance come government appropriations, which accounted for 34.1 percent of total receipts. Interest on investments, amounting to \$188.1 million, makes up the remainder.

It has always been intended that the Federal government bear a substantial part of the cost of the system. For the first eight years, however, the government made no appropriations to meet its share of the obligations incurred. Beginning in 1929 with \$19,950,000, the government had appropriated a total of \$3 billion by the end of June 1952. For the fiscal year ending in 1952, the appropriation was \$313 million.

The Civil Service Commission estimates that employees bear about 15 percent of the cost of the benefits provided, the remainder being an obligation of the Federal government. The proportion of the total annuity assumed by the government has always been at least equal to and generally greater than the amount purchased by the employee's accumulated compulsory contributions. In 1935 it was 95 percent of the total, but by 1945 it had been reduced to 88 percent. The lower the individual's income, the higher the proportion assumed by the government. For annuitants added to the roll in the fiscal year ending in 1946, for example, the government's contribution for those whose salary was less than \$900 amounted to approximately 97 percent of the total annuity. For those with salaries between \$2400 and \$2799 it was approximately 82 percent, and for those with salaries of \$5000 or more it was about 80 percent.

Cost of Administration. For the fiscal year ending in 1951 a total of \$1,334,000 was spent for administration. There were 352 employees in the Commission whose work it was to operate the system. Altogether that year, a total of 47,500 claims for annuities and death benefits were processed, and in addition there were processed 28,000 claims for credit for past service, and 183,000 claims for refunds of retirement deductions by employees who were separated from the service. The Commission estimated that in 1951 it cost \$7.22 to process a claim for an annuity filed by a retiring employee or a death benefit claim filed by the survivors of a deceased employee. Many inquiries are received by the Commission concerning the nature of the program and especially about a specific claim. There were more than 200,000 of these in 1951.

The processing of claims is handled with dispatch, and this is one test of administrative efficiency. In 1951 it required an average of only 18 workdays to process a claim for a retirement annuity, 17 days to process a death benefit claim, and only 10 days to make a refund of contributions to a separated employee withdrawing from the system. This record is much better than that for the fiscal year ending in 1947, when 40 days were required to process a retirement claim, 44 for a death benefit claim, and 20 for a refund of contributions.

The Reserve. The balance in the reserve fund as of June 30, 1952, was \$5037.0 million, which represents the difference between total receipts of \$7999.7 million and total disbursements of \$2962.7 million. This balance was not adequate to meet liabilities accrued as of that date. Total accrued liabilities as of June 30, 1952, were estimated to be \$9975.4 million; and since the funds on hand in the reserve amounted to \$5037.0 million, the deficit was thus \$4938.4 million. Practically all of this deficit represented prospective annuity benefits based on past service by active and separated employees not yet retired and in excess of the amount their contributions with accumulated interest would provide.

That the Federal government's obligation with respect to the annuities provided by this system has not been fully funded by adequate appropriations for the reserve account does not mean that the system is bankrupt or in any danger of collapsing. It means simply that in this operation a kind of deficit financing has been followed. Contributions made by employees, plus the interest earned on them, were sufficient to meet all disbursements until 1934. Federal appropriations began before that and have been more than enough to make up the difference between income and expenditures. But they have not been adequate to build up the reserve to an amount which would provide enough interest to make up the difference between contributions and accrued liabilities. In other words, there is not enough on hand and in sight to meet what employees have now earned in the way of benefits and which they will in due time ask for. In effect the government has contracted a debt of nearly \$5 billion. Possibly the government will never fully fund its liability under the Act. Nor is it really necessary that the liability ever be fully funded. Congress can meet its unfunded obligation by appropriating money enough to pay interest on that portion of its liability, thus providing the difference between other income and expenditures.

Essentially that is what it would do if the unfunded liability were wiped out by special issues of bonds. That money will come ultimately from taxes paid by the public, which basically is the employer of civil servants. So long as the government is able to collect the taxes, or for short periods of time to borrow, the system will be financially sound.

Comparison with Federal Old-Age and Survivors Insurance System. In some rather vital respects the civil service system is superior to the Federal Old-Age and Survivors Insurance system. For one thing, it provides for optional retirement at ages below 65. To be sure, an employee retiring at an earlier age suffers some reduction in the size of his annuity unless he has the requisite years of service. But as indicated in the data given earlier, the option of retiring early is exercised by large numbers. For the worker, this provides a highly desirable flexibility.

Another element of superiority in the civil service system is the provision for disability retirement; this has no counterpart in the social security system. Somewhat more than 27 percent of all retired annuitants on the rolls at the end of June 1952 had retired because of disability. That large numbers under the social security system would avail themselves of a similar opportunity is clear. And it has been primarily because of fear that the provision would be grossly abused that one has not yet been enacted into the social security system.

Long-service employees, and their survivors as well, receive appreciably higher annuities than do those in the social security system. In the civil service system benefits are directly related to length of service. In the other system they are related indirectly, through the effect of "time elapsed" on the average monthly wage. But the value of additional years of service is greater in the civil service system. The incremental factor in the social security system which allowed additional amounts for years of service was eliminated in 1950. In general, the highest wage period reached by the worker is used as the basis for computing the annuity in the civil service system, whereas the average of the entire period is used in the general system, and wages in excess of a specified maximum are not counted. Furthermore, retired civil service annuitants are not faced with the same severe restrictions on the amount they are permitted to earn without losing their annuities. This is a marked advantage. The "new start" beginning in 1951 with its liberalized formulas reduced

to some extent the difference in size of annuities of the two systems, and the 1952 and 1954 amendments reduced it even more, but there is still a great disparity.

There is still another important advantage. Civil service employees who serve the minimum number of years, namely 5, may quit covered government employment altogether and retain the right to receive an annuity based on their earnings and service when they reach the proper retirement age. In a sense the same is true of persons covered by the Federal Old-Age and Survivors Insurance system. Under it an employee can become permanently fully insured, and this carries with it the right to a benefit. But the amount of time one must work to acquire this status is variable, and for all it will eventually be a minimum of 10 years. The size of the benefit under the social security system, if it is above the absolute minimum guaranteed to all, varies with the amount of time elapsing after leaving covered employment, which is not the case in the civil service system.

There are other respects, however, in which the civil service system is not as favorable as the Federal Old-Age and Survivors system. In the civil service system employees do not acquire any retirement rights until they have had at least 5 years of service. Transfer to another employer means loss of that time. In the general system, transfer to another employer is not likely to cause any loss, since most employers are covered. Protection to survivors under the social security system begins when the worker acquires a "currently insured" status, which may require as little as 6 quarters of coverage. For civil service employees this is not so. They must have completed the minimum of 5 years of creditable civilian service. Furthermore, under the general system, as long as a person is either currently or fully insured his dependents have some protection in the event he dies, whether he is employed or not. Under the civil service system only survivors of deceased employees or annuitants have that protection. It is lost immediately on termination of government employment.

The survivors of deceased short-term civil service employees receive small annuities, because of the short service. Under the general system the benefits are likely to be relatively higher. This is true because short-service employees are likely to be young, and the formula for determining their average monthly wage does not count some of the time elapsed. Absence in the general system of the in-

cremental factor allowing for years of service eliminates length of employment, as between those employed, in determining benefit amounts. Maximum limitations on children's benefits under the civil service system are such that in many cases families of fully orphaned children receive more money than if the mother were living.

Benefits under the civil service system are better than those paid under the other system partly because the employees covered pay more for them. Mostly, however, it is because their employer, the Federal government, pays more. This brings out a basic difference between the two systems. The Federal Old-Age and Survivors Insurance system is designed to provide only basic minimum amounts. It is expected—perhaps it would be better to say hoped—that employers will supplement the amounts thus provided, either through a purely gratuitous or a contributory system, individually, or through collective bargaining. Considerable progress has been made in supplementing social security benefits. The civil service system is in effect an individual employer program. It is not supplemented by any other program, and is not designed to be so supplemented, except by individual savings. It should therefore provide greater benefits, and those greater benefits do not represent discriminatory action by the Federal government.

SOME OTHER ACTS

The Civil Service Retirement system covers most Federal civilian employees. However, special provision outside that system is made for some officers and employees. No attempt will be made here to deal with all these special arrangements. But those administered by the Civil Service Commission will be reviewed briefly.

The Panama Canal and Alaska. Before 1949 there were separate retirement systems for the Canal Zone and the Territory of Alaska. They covered workers who were citizens of the United States and whose tenure of employment was not intermittent or of uncertain duration.

The employees covered by these two systems were absorbed into the Civil Service Retirement system. The plans were already being administered by the Civil Service Commission and consequently merging them with that system did not involve exceptional administrative problems. Amounts deducted from employees' pay while under the two systems were credited to their account in the Civil Serv-

ice Retirement system, accumulated at 4 percent interest for the years before 1948 and at 3 percent since then. Some special features of the two systems were retained.

Retirement is compulsory for these workers at age 62 after 15 years of service on the Isthmus of Panama or in the Territory of Alaska, although the President may exempt any employee from this provision. This is in contrast to the 70-year compulsory retirement for other civil service employees. The annuity payable under the regular system is first computed and to it is then added the sum of \$36 times the number of years served on the Isthmus or in the Territory of Alaska with the canal or the railroad. Refunds and annuities for those separated before the two systems were merged are determined according to the provisions of the two systems rather than of the regular system.

As of June 30, 1949, the last year of its separate existence, there were 1151 annuitants on the Canal Zone retirement roll, and all but 32 had the nonforfeiture type of annuity. In age they averaged 66.0 years, with an average of 26.7 years of service, of which 24.8 were spent on the Isthmus. They received in annuities during that year a total of \$1,723,606, or an average of \$1497, this having risen gradually from \$1315 in 1932. The amount purchased by voluntary contributions was small, averaging only \$266. Average contributions made by these annuitants while working under the system, including interest, was \$3372. Total liabilities incurred in the operation greatly exceeded assets on hand, being \$11.3 million compared to \$2.9 million, or a deficit of \$8.4 million. This deficit, of course, is an obligation of the United States government.

The Alaska railroad operation was even smaller. On June 30, 1949, there were only 189 annuitants on the roll. In age they averaged 68.8 years, with an average of 20.5 years of service, of which 19.4 were with the Alaska Railroad Company. The total paid out in annuities that year was \$209,146, or an average of \$1107. The largest annuity was \$1716 and went to a man who retired voluntarily at age 60 after 30 years of service, all with the Alaska Railroad Company. Employees purchased an average of \$205 with voluntary contributions. Compulsory contributions, including interest, averaged \$2200. There was also a deficit in this system, although it was small. Reserves amounted to \$1.7 million and liabilities to \$1.8.

Panama Canal Construction Pensions. Construction of the canal was a difficult and hazardous undertaking, and the Congress

has seen fit to give special rewards to American citizens who participated in the project. A few officers, singled out by name, were awarded an advance in military grade in 1915. Other officers of the Army, Navy, and Public Health Service who had served more than three years on the Isthmus during the construction period were at the same time allowed an advance of one grade on retirement or if they had already retired. Such officers were also privileged to retire upon application, irrespective of age, at 75 percent of the pay for the rank they held upon retirement, not the advanced rank to which they would be promoted upon retirement.

The service of civilians on the project was not given special recognition until 1944. In that year Congress formally recognized the "distinguished service" rendered by them in the construction, maintenance, operation, sanitation, and government of the canal during that trying period. Annuities were granted to workers who for three years or more during the period May 4, 1904, to March 31, 1914, inclusive, had been engaged with or employed by the Isthmian Canal Commission or the Panama Railroad Company on the Isthmus and who were living on the date the Act became effective, i.e., May 29, 1944. These annuities began as of the month following the effective date and were not payable for any period of time before it. In the original law the annuity was made payable only to those who were American citizens during their service on the Isthmus, but two years later it was extended also to those who had become naturalized citizens on or before December 7, 1941.

In size, the individual annuities vary according to years of service and pay received. Only the basic pay is counted in computing the annuity, thus bonuses, allowances, overtime, and extra pay of any other kind are all excluded. Employees who served at least three but less than four years were granted 40 percent of their average annual basic pay for the period served, those serving four but not more than six years were allowed 50 percent, and those serving more than six years were allowed 60 percent. At first the annuity ceased if any special reward or any other annuity was received for this same service. People who stayed on, for example, and became eligible for a retirement annuity under the Canal Zone system or under the regular system could not receive both annuities. That restriction was removed in June 1948.

Many of those who served on the Isthmus during the construction period died before the law was enacted. The law provided that the

surviving widow of a deceased man who would otherwise have been eligible for an annuity was entitled to receive it in his stead, provided she had lived with him for at least one year on the Isthmus during the construction period, was not divorced from him, and had not remarried. This is payable until death or remarriage. Undivorced and unremarried widows of annuitants receive the same annuity, provided they also meet the one-year residence requirement. The amount of this widow's annuity, it should be noted, is the same as the annuitant himself received or would have been entitled to.

By June 30, 1945, the end of the first full fiscal year after the law was enacted, a total of 1910 annuitants had been placed on the roll. Of these, 1428 men and 91 women were former employees, and 391 were widows of former employees. Thereafter until 1949 only small numbers were added each year, but almost as many were dropped from the roll, mostly because of death. In 1948 the provision prohibiting payment of this annuity with any other based on Isthmian service was repealed. As a result the roll in 1948-1949 saw the addition of 1083 persons. Since only 77 of these were widows, it is obvious that many were already receiving an annuity under some other government system. At the end of June 1952 there were 2977 on the roll, of whom 2263 men and 122 women were former employees and 592 were widows. The enrollment peak was reached in 1951, when there were 3044 annuitants. The number will gradually decline.

The average annuity under this plan on June 30, 1952, was \$749. For men it was \$700, and for women who were former employees it was only \$411. Widows were receiving more than the former employees, their average annuity being \$1007. The total amount paid out in annuities by the end of June 1952 was \$20.2 million, the annual payment being about \$2.5 million. This is a purely gratuitous pension system, no payments whatsoever having been made by the former employees.

Lighthouse Widows' Annuities. There is a pension system for officers and employees in the Lighthouse Service; it does not include workers in district offices or shops and is not applicable to field service employees who are not on substantially full time. Employees may retire at age 65 after 30 years of government service; they must retire at age 70. The pension, or annuity, granted to them consists of one-fortieth of the average annual compensation for the last five years of service, not counting subsistence or other allowances, for each year of government service, but with a maximum of thirty for-

tieths. There is also provision for disability retirement after 15 years of service. This pension system is not administered by the Civil Service Commission. But in 1950 Congress provided annuities for the widows of these employees, and these are administered by the Commission.

The widow of any former employee receiving or entitled to receive an annuity (except widows of men in professional and scientific grades) who married him prior to his retirement from the Lighthouse Service, is entitled to a pension of \$50 a month as long as she lives. This pension terminates if she remarries. It is also provided that the widow of an active employee who died from a non-service-connected disability after 15 years or more of Lighthouse service shall receive a similar annuity as long as she does not remarry. No age limitation is specified in either case as a condition of eligibility.

Payments were first made for September 1950, and no payments were made for periods before that date. This also is a purely gratuitous pension.

PART THREE

UNEMPLOYMENT

CHAPTER NINE

THE PROBLEM OF UNEMPLOYMENT

UNEMPLOYMENT from one cause or another is an age-old phenomenon, antedating industrial society and existing among collectors, hunters, fishers, and pastoral and agricultural peoples. Erratic variations in seasonal timings, sporadic storms and other natural disturbances, rhythmic fluctuations in weather conditions, and vagaries in the movements of migratory animals contributed to involuntary idleness in the regular occupations of workers in primitive societies and ancient times. That the effects on those concerned were serious, and sometimes even catastrophic, there can be little doubt. It is possible, perhaps even probable, that the relative amount of unemployment and its effects were greater and more serious in primitive than they are in contemporary society.

The incidence and effects of unemployment in modern industrialized economies are not simply what they were in primitive societies. The burden exists in both types, and it must be borne. But specialization, the wage system, and inequality in job tenure result in a greater concentration of that burden among certain segments of our economy. The effects on the individual concerned are relatively worse than when the incidence was on the community as a whole. As one writer has said:

The situation of the man who cannot find employment has its peculiar misery. He is, of course, like the man who is sick or too old for employment, without an income, but unlike the latter he is without the physical excuse for his situation. Being without this excuse, he tends to feel even when he has an intelligent understanding of the economic organization of the modern world, that somehow there must be something wrong with him or he would not be in his predicament. Especially where his unemployment is prolonged, this sense of personal failure creeps in, to add to

the economic distress he suffers. . . . And when, able-bodied and willing to work, he is forced to ask for charitable assistance for his family, the injury to his morale is often a more serious loss to the community than the money paid out for his assistance.¹

Furthermore, in representative democracies, severe and prolonged unemployment breeds demagogues and quacks whose doctrinaire solutions based on simple assumptions never tested by experience have a great popular appeal because they promise so much to so many for so little. Such unemployment constitutes a menace to social and political stability and to orderly processes of improvement.

The extent of unemployment confronting us during the 11 years preceding World War II was so great, the hardship and suffering resulting from it so intense, and the amount spent in relief so tremendous that it is fair to say that unemployment was for over a decade our major economic and social problem. It was not uncommon to hear it said that we were permanently doomed to have an excessively large volume of unemployment, and some are still convinced that the evil day has merely been postponed. What the future has in store for us in the way of unemployment, no one really knows, and least of all those who predict most freely and dogmatically. Of one thing, however, we can be reasonably sure. there will always be some unemployment and at times a great deal of it.

It is, of course, true that the most serious types of unemployment do not descend upon us out of the blue, but are themselves results of something else which is fundamental to the capitalistic processes. But economists are not generally agreed upon what that something else is. In any event, most people are unemployment conscious rather than process conscious, and technical disputes about fundamental causes leave them cold—especially the unemployed.

The study of basic economic processes is more fundamental and therefore more important than is the study of any one manifestation of those processes. But here we are primarily concerned with the volume of unemployment and its distribution rather than with the basic economic processes of price and income determination, and for the simple reason that we are here concerned with the problem

¹ Barbara Nachtrieb Armstrong, *Insuring the Essentials*, The Macmillan Company, 1932, p. 464. For an exaggerated statement of the effects of unemployment, see Don D. Lescohier, *The Labor Market*, The Macmillan Company, 1919, pp. 106-108.

of distributing among many a part of the financial burden of unemployment. For, whatever may be the cause or causes of unemployment, the function of unemployment compensation is primarily to distribute the burden involved and not to reform the economic system. Those interested in the basic theories of employment and unemployment are referred to the major economic journals, where the theories are ably debated by experts in disagreement.

THE EXTENT OF UNEMPLOYMENT

That there are many people out of work at all times and that during depressions the number mounts to large proportions are commonly known facts, but concerning the actual extent of unemployment in times past we have little information.² We have long been a statistically-minded nation, much interested in quantitative movements from year to year and from month to month, primarily, however, in the movements that spell profit or loss for business. Data on major social and economic problems have interested us only when the problems became pressing, usually too late to develop useful time series. As our unemployment compensation systems become more extensive in scope and accumulate more experience, substantial and comparable data will become available.

Numbers Unemployed. One of the most reliable, or least unreliable, set of estimates of unemployment, covering a period of thirty years, was made by Professor Paul H. Douglas, for manufacturing, transportation, the building trades, and mining. Those estimates are presented in Table 26.

The Douglas estimates exclude certain relatively stable industries, such as trade, public utilities, public employment, domestic, personal, and professional services. Professor Douglas believes that if allowance were made for such exclusions the percentages would be decreased by one or two points. Furthermore, unemployment resulting from sickness is included in the estimates. Allowance for both of these would, he thinks, reduce the percentages given by two points.

² See Arthur R. Reede, "Adequacy of Employment Statistics," *Journal of the American Statistical Association*, March 1941, pp. 71-80; Aryness Joy, "The Meaning of Unemployment Statistics," *ibid.*, June 1941, pp. 167-174; R. A. Nixon and P. A. Samuelson, "Estimates of Unemployment in the United States," *Review of Economic Statistics*, August 1940, pp. 101-111.

The average volume of unemployment in the industries studied was 10 percent, which if reduced to allow for stable industries and sickness would be 8. During "good" times the percentage rarely fell below 6, or making allowance for the more stable industries and sickness, 4. A definite cyclical movement is apparent, which is believed to account on the average for about 4 percent of the time lost in these industries. But Professor Douglas found no "observable and

TABLE 26. Unemployment in Manufacturing, Transportation, Building Trades, and Mining, 1897-1926 ³

Year	Total Unemployed (Thousands)	Percentage Unemployed	Year	Total Unemployed (Thousands)	Percentage Unemployed
1897	1266	18.0	1912	775	7 0
1898	1214	16 9	1913	936	8 2
1899	766	10 5	1914	1899	16 4
1900	755	10 0	1915	1822	15 5
1901	584	7.5	1916	774	6 3
1902	569	6.8	1917	774	6 0
1903	609	7.0	1918	719	5 5
1904	883	10.1	1919	880	6 9
1905	622	6 7	1920	938	7 2
1906	577	5.9	1921	2913	23 1
1907	695	6.9	1922	2338	18 3
1908	1654	16.4	1923	1010	7 9
1909	925	8.9	1924	1506	12 0
1910	774	7.2	1925	1120	8 9
1911	1025	9 4	1926	962	7 5

pronounced tendency for the volume of unemployment either to diminish or increase."⁴

The decennial census of unemployment is a simple count made by the Federal government as of a given time. The count is made by tens of thousands of persons temporarily employed for that purpose. Definitions of unemployment have varied as has the time of year as of which the count was made. Consequently the figures compiled are not as accurate as they might be and are not usually directly comparable.

³ Paul H. Douglas, *Real Wages in the United States*, McGraw-Hill Book Company, Inc., 1930, p 460

⁴ Paul H. Douglas and Aaron Director, *The Problem of Unemployment*, The Macmillan Company, 1931, p 33

For April of 1930, which was early in the Great Depression, the census showed that there were 3,187,647 totally unemployed, not counting those who were voluntarily idle or those who were ill, although it did include some who were part-time workers and not at work on the workday preceding the enumerator's visit⁵ There were 48,823,589 persons 10 years of age or over gainfully occupied, and the totally unemployed constituted 6.5 percent of that force. Experts are of the opinion that the figure appreciably understated the number out of work.

The census count of 1930 provided "bench marks" which served as bases for current estimates of unemployment. There were several such estimates which purported to show the volume of unemployment from month to month, among the most important of which were those made by the American Federation of Labor, the National Industrial Conference Board, the Cleveland Trust Company, and the Alexander Hamilton Institute. The method used in arriving at the estimates was in general to subtract the estimated number of persons working from an estimated labor force. There was a generous "leaven of estimate" in the resulting indexes.

A voluntary registration taken by mail in 1937 showed 7.8 million unemployed, but a check census taken shortly afterwards resulted in an estimate of 10.8 million unemployed. Current estimates at that time ranged from 7.2 million to 9 million.

The census of 1940 revealed considerable error in current unemployment indexes. Total population for that date was roughly 131,500,000, which was about 750,000 fewer than the current estimates. A sample analysis of data showed 7.5 million out of work during the last week in March, which, making allowance for an apparent undercount of persons engaged in Federal emergency work projects, could reasonably be increased to 8 million. Complete returns made later showed 7,961,000 unemployed, representing 14.9 percent of the labor force. Current estimates of unemployment varied from 9.2 million by the National Industrial Conference Board, 10.3 million by the American Federation of Labor, to 11.5 million by the Congress of Industrial Organizations. The chief source of error lay in the estimated current employment, and it resulted from the fact that the U.S. Bureau of Labor Statistics index of current

⁵ For an intensive analysis of unemployment statistics for the period 1930-1938, see W. S. Woytinski, *Three Aspects of Labor Dynamics*, Social Science Research Council, 1942.

employment in nonagricultural pursuits was entirely too low.⁶

The United States Bureau of Labor Statistics has made estimates of the volume of unemployment for the years 1929–1940, which are accepted as the best available for that period, and its annual averages are shown in Table 27, together with official estimates made by the Bureau of the Census for subsequent years.

TABLE 27 Estimates of Unemployment, 1929–1946 ⁷

Year	Number Unemployed (Thousands)	Percentage of Civilian Labor Force	Year	Number Unemployed (Thousands)	Percentage of Civilian Labor Force
1929	1,499	3.1	1938	9,910	18.7
1930	4,248	8.8	1939	8,842	16.5
1931	7,911	16.1	1940	8,120	14.6
1932	11,901	24.0	1941	5,560	9.9
1933	12,634	25.2	1942	2,660	4.7
1934	10,968	21.6	1943	1,070	1.9
1935	10,208	19.9	1944	670	1.2
1936	8,598	16.5	1945	1,050	1.9
1937	7,273	13.8	1946	2,270	3.9

The magnitude of the depression beginning in 1929 is clearly indicated in the volume of unemployment during its worst years, namely 1932–1936, and the severity of the recession beginning late in 1937 is revealed in the marked increase in unemployment the following year. Never before had there been such severe and prolonged unemployment, although shorter periods of almost equal severity are indicated in the Douglas figures given above. The Second World War resulted in the almost complete elimination of unemployment. It is worth while to stress the fact that even during the year of most intensive activity, when man power was critically short, there were 670,000, or 1.2 percent of the civilian labor force, unemployed. In a large, varied, and dynamic economy, there is always some unemployment.

Duration of Unemployment. The burden of total unemployment is by no means adequately indicated by the number of persons

⁶ W. S. Woytowski, "Controversial Aspects of Unemployment Estimates," *Review of Economic Statistics*, May 1941, pp. 72–74.

⁷ Florence Peterson, *Survey of Labor Economics*, Harper & Brothers, 1947, p. 139; Bureau of the Census, Current Population Reports, *Employment and Unemployment in the United States, 1940 to 1946*, Labor Force Bulletin Series P-50 No. 2, pp. 11–17.

out of work. For the duration of individual unemployment is also an important factor. Existing information on the duration of unemployment is scanty and unreliable for many reasons, and it is therefore not possible to draw a good picture for the country as a whole or for major industries over a reasonable period of time.⁸

It may be said that before 1930 it rarely happened that any substantial number of individuals were unemployed for more than six months. There were periods when the percentage unemployed was exceedingly high, but except for 1893–1898 the period of time over which depression extended was short. Labor turnover was high, but separations were predominantly quits rather than layoffs.⁹

The depression which began in 1929 was an exceptionally long one. Turnover rates were not appreciably higher than during the preceding 10 years, but separations were overwhelmingly layoffs rather than quits. Substantial numbers of individuals were unemployed for long periods, in many cases four, five, and six years. Surveys made in Philadelphia from 1931 to 1938 showed duration by sex and time intervals.¹⁰ Of the enumerated male unemployed, the percentage idle for five years or more declined from 0.9 in 1931 to 0.8 in 1932, increased to 21.6 in 1937, and declined to 14.8 in 1938. The percentages for women were somewhat lower.

These data are not to be considered as typical of the entire country, but rather as illustrations of the general trend in good and bad times. A suggestive glimpse into the changing structure of the length of individual unemployment is afforded by W. S. Woytinski in the following words "During a heavy depression, the whole pyramid of unemployment resembles an obelisk, while in prosperous years its slopes are characteristically gentle."¹¹

The "Hard Core." The "hard core" of unemployment consists of unemployed workers who, though able and willing to work, have practically no chance of being reemployed unless or until business

⁸ For an analysis of data up to about 1940, see W. S. Woytinski, *Three Aspects of Labor Dynamics*, Social Science Research Council, 1942.

⁹ Sample surveys made in Columbus, Ohio, for the years 1921–1925 show that those unemployed for 52 weeks or more constituted 10.8 percent of the total in 1921, 16.7 in 1922, 5.1 in 1923, 4.6 in 1924, and 6.9 in 1925. The total number of enumerated workers unemployed declined from 1079 in 1921 to 238 in 1922, increased to 491 in 1924, and declined again to 403 in 1925. Fredenc E. Croxton, *Unemployment in Columbus, Ohio, 1921 to 1925*, U. S. Bureau of Labor Statistics Bulletin No. 409.

¹⁰ Cited by Woytinski in *Three Aspects of Labor Dynamics*, p. 100.

¹¹ *Ibid.*, p. 72.

conditions improve materially. There is always something of a core, but when business is good the size is insignificant.

The core consists in part of workers made marginal by "gradual negative selection." Some employers are hesitant to employ persons who have been out of work for long periods of time if others are available, except of course their own former employees. They may fear that there has been some deterioration in the quality of the worker, a decline in skill and morale. Prolonged unemployment does adversely affect skill and morale, but probably not nearly so much as generally supposed.

In part the core consists of workers made idle by other factors and circumstances. Geographical shifts in establishments are not uncommon, but workers do not easily shift with them, and pools of stagnant labor are left behind. The growth of more efficient establishments elsewhere frequently reduces employment in some existing plants, and changes in consumers' demand leave residues of immobile workers, men and women caught in the backwash of the stream of change.

During the depressed Thirties, many believed that the hard core was to remain a substantial and permanent phenomenon of our "matured" capitalistic system. The Second World War almost completely eliminated the core. Whether another substantial core will develop, and if so how soon, is a matter for conjecture. Such an occurrence does not appear to be unlikely, but the probability that it will develop in the near future does not appear to be great.

"Additional" Workers. Another phenomenon of the labor market not previously given much consideration became marked during the Great Depression and the Second World War. Many persons not normally gainfully employed or a part of the labor force come into the labor market under certain conditions. These are not the persons who provide us with the extra man power needed to handle seasonal operations, such as students on vacation, unpaid family workers and others more or less regularly available for such work. But they are men and women, boys and girls, who flow into the market when business booms and when it busts, who "normally" would not be working for money. In the past twenty years, unusually large numbers of these "additional" workers have sought jobs.

During a depression, additional workers enter the labor market to provide the family with an income or to supplement the usual breadwinner's reduced earnings, or as a "hedge" against antici-

pated unemployment of the breadwinner or a reduction in his income. Their presence swells the volume of unemployment, and complicates the problem of estimating that volume. Those who do not get jobs, and in bad times most of them do not, cause what is called "secondary" unemployment. Mr. Woytinski has estimated that census returns in 1930 included from 120,000 to 150,000 additional workers, that in 1931 there were from 600,000 to 650,000, and in 1937 from 900,000 to 1,000,000.¹²

In times of intense business activity, additional workers enter the market to share in the lush earnings and some do so for patriotic reasons in time of war. Most of them get jobs and therefore cause little unemployment. The United States Bureau of Labor Statistics estimated that the number of "extra" workers in our labor force in April of 1944 was 6.7 million, and 7.3 million in April of 1945, mostly young people of school age and married women with no children.¹³

Partial Unemployment. In describing the volume of unemployment, primary emphasis is placed on the number totally unemployed and the duration of their unemployment. There is also normally a considerable volume of partial unemployment, but as yet we know little about its nature and extent. We do know that it is widespread and that the volume fluctuates with the business cycle.

Studies of unemployment made in 29 cities at various times in 1915 by the Metropolitan Life Insurance Company and the United States Bureau of Labor Statistics showed that many workers were employed only part time. Figures for the East and Middle West, for example, showed that 11.5 percent of the persons surveyed were totally unemployed, and that 16.6 percent had jobs but were not employed full time. There was considerable variation as between cities, Pittsburgh, Pa. being high with a percentage of 29.0 and Springfield, Mo. low with 1.4.¹⁴

A later study limited to Columbus, Ohio, covered a longer period of time.¹⁵ The proportion of persons enumerated who were partially employed and the amount of time employed in the various years are shown in Table 28.

¹² *Ibid.*, chap. x. But see John D. Durand, *The Labor Force in the United States, 1890-1960*, Social Science Research Council, 1948, pp. 101-102.

¹³ *Monthly Labor Review*, November 1945, pp. 841-844.

¹⁴ U. S. Bureau of Labor Statistics Bulletin No. 195, p. 6.

¹⁵ Frederic E. Croxton, *Unemployment in Columbus, Ohio*, U. S. Bureau of Labor Statistics Bulletin No. 409.

The year 1921 was bad in Columbus, Ohio, because of the depression, but 1924 was worse so far as the percentage of workers on part time was concerned. The best year was 1923, both in the total percentage of part time and in the proportion among those with employment of half time or better. However even the worst years were not particularly alarming. If only 10 or 12 percent are working short time and 75 percent of those are working at least half time, the problem is not a serious one. Other data suggest that this was true for manufacturing industries as a whole up to 1930.¹⁶

TABLE 28. Percentage of All Persons Enumerated in Columbus, Ohio, 1921 to 1925, Who Were Employed Part Time ¹⁷

Amount of Employment	Years				
	1921	1922	1923	1924	1925
Total part time	10 1	6 6	6.2	12.1	9.7
Two-thirds but less than full time	2.5	2 2	2.6	5.0	4.3
One-half but less than two-thirds	5 8	3.2	2 9	4 9	3 9
One-third but less than one-half	1 2	0 7	0.6	1 7	1 0
Less than one-third	0 6	0 5	0.1	0 5	0 5

A different picture must be painted for the depressed decade beginning with 1930. Accurate and comprehensive data are not available for that period either, but there are enough to suggest forcefully the vast amount of part-time work, especially during the first half of that decade. The number out of work was so great that a strong "spread-the-work" movement developed, and spreading work was erroneously called by some "increasing employment."¹⁸ For the pay-roll period ending nearest March 15, 1932, it was estimated that 56.1 percent of the workers were on part time, and they averaged 58.7 percent of full time. In the machinery and rubber groups, 84.9 percent of the employees were on part time, as against 20.4 percent of those employed in commercial establishments. It is possible that by March 1933, the low point in the depression, the situation was even worse.

¹⁶ *Social Security in America*, Social Security Board, 1937, chap. iii, p. 65.

¹⁷ U.S. Bureau of Labor Statistics Bulletin No. 409

¹⁸ Mr. William J. Barrett, of the President's Organization on Unemployment Relief, "Extent and Methods of Spreading Work," *Monthly Labor Review*, September 1932, pp. 487-492.

As the depression lifted, the situation improved, but the sharp recession in 1937 was accompanied by an increased volume of short time. The voluntary registration census taken by mail November 16-20, 1937, returned 7,822,912 as totally unemployed and 3,209,211, which is just under 41 percent of the number totally unemployed, as partially employed and wanting more work. However, the check census taken immediately afterwards by postal employees and covering 1,950,000, or 1.5 percent of the population, resulted in an estimate of 10,870,000 totally unemployed and about 5,630,000 partially employed. The underregistration of the partially employed was apparently much greater than of the totally unemployed in the voluntary registration.

Irregularity of Employment in 1939. The amount of unemployment varies from time to time, and the proportions of it which can be attributed to the different causes depend upon the relative intensity at that time of the different factors which bring it about. There is no index of irregularity of individual employment. But the census taken in April of 1940 provides some information on the number of weeks persons were employed in 1939. The data given below are for wage and salary earners and include employment on public emergency projects and unpaid family labor. Returns were made in many cases by a member of the worker's family rather than by the worker himself. Furthermore, most persons who are asked in April of one year to tell how many weeks they worked in the preceding calendar year must rely on their memory, and memory is not very accurate. A large proportion of the returns were therefore approximate, as is evidenced by a marked tendency to report employment in multiples of four weeks. The conclusions drawn from these data are to be accepted with reserve and should be considered as rough approximations of what happened. So considered, they are useful.

Table 29 shows the total number of persons who worked in 1939 and percentages according to time worked, separately for men and women. Time worked includes paid vacations and other absences with pay, but not summer vacations of teachers who were not employed during the summer. Part-time work is combined into equivalent full-time periods.

More than half of those who reported work in 1939 were employed for the entire year and approximately 70 percent of those

who worked had substantially full employment. A significant percentage, 13.3, had employment totaling from six to eight months. Relatively few had less than three months of employment. Irregularity was greater among women than among men, as would be expected. Teachers are employed in schools an average of approximately 10 months, and substantial numbers of them, especially the women, would report less than full-time employment. Yet after all proper allowances are made, it appears reasonable to say that a substantial amount of irregular employment existed in 1939, which is generally considered the most nearly normal year between 1930 and 1949.

TABLE 29. Months Worked in 1939 by Persons Who Were Wage or Salary Workers in 1940 ¹⁹

Employment Status	Male		Female		Percent of Total
	Number	Percent	Number	Percent	
Without work	1,322,376	4 5	798,317	7 2	5 2
Work not reported	520,737	1 8	288,233	2 6	2 0
With work	27,583,784	93 7	10,062,235	90 3	92 8
Less than 3 months	849,883	2 9	524,492	4 7	3 4
3 to 5 months	2,190,392	7 4	982,670	8 8	7 8
6 to 8 months	4,016,456	13 6	1,380,378	12.4	13 3
9 to 11 months	4,778,905	16 2	1,838,708	16 5	16 6
12 months	15,748,148	53 5	5,335,987	47 9	52 0

Irregularity varied considerably as between industries and occupations.²⁰ The food industries, trade, public utilities, finance, insurance and real estate, males in professional service, and government employment all showed full employment for more than 60 percent of the persons working in them. The highest percentage of full-time employment was in finance, insurance, and real estate, with 80.8; the lowest was for males in coal mining, 10.8. In manufacturing, employment was most stable in occupations producing perishable consumers goods, 64.4 percent being employed full time, less stable

¹⁹ Bureau of the Census, *Sixteenth Census of the United States, 1940 Population*, vol. iii; *The Labor Force, Part I*, adapted from Table 88 on p. 273 and Table ix on p. 13.

²⁰ *Sixteenth Census of the United States, 1940, Population*, vol. iii, *The Labor Force, Part I*, pp. 274-275, Table 89

in those producing durable goods, where about 50 percent had full-time employment, and least stable in occupations producing semidurable goods, where only 58.6 percent had 12 months of employment.

It is not possible to say how many of those employed less than full time were irregularly employed because they preferred to be so, but it is known that many work part time as a matter of preference, especially married women with children to care for.

The same general picture can be seen from a different angle for later years. The Bureau of the Census publishes estimates of the number of persons employed for specified numbers of weeks, which are based on returns from a small but scientifically determined sample enumeration. Estimated annual averages are given in Table 30.

TABLE 30. Persons 14 Years and Over Working in Nonagricultural Industries, by Hours Worked, 1940-1946 ²¹

(In Thousands)

Hours Worked per Week	1940	1941	1942	1943	1944	1945	1946
35 or more	31,490	35,240	38,230	39,690	38,060	36,540	39,460
15 to 34	4,340	4,070	4,100	3,510	4,230	4,540	4,200
1 to 14	1,230	1,120	1,160	1,060	1,170	1,370	1,210

Relatively few people worked short time during the defense and war years. In 1940, 85 percent worked 35 hours or more per week, and the percentage continued to increase, reaching a peak in 1943 when it was 89.7. Thereafter a slight decline set in for two years, but the postwar boom sent the 1946 percentage to 87.9. The percentage of those working from 15 to 34 hours moved in the opposite direction, declining from 11.7 in 1940 to 7.9 in 1943, then up to 10.7 in 1945 and down again to 9.4 in 1946. The percentage working from 1 to 14 hours exceeded 3 in only 1940 and 1945. During good years there is some irregularity of employment, but not an alarming amount, and much of it is without doubt voluntary in character.

²¹ Bureau of the Census, Current Population Reports, *Employment and Unemployment in the United States, 1940 to 1946*, Labor Force Bulletin Series P-50 No. 2, pp. 25-26.

CAUSES OF UNEMPLOYMENT

However inaccurate estimates of unemployment may be, we know that there is much of it, even in good times. We also know something about the superficial "causes" of that unemployment, although there is much difference of opinion about the relative importance of some of the causes. The individual causes of unemployment are exceedingly numerous and it would be impossible to enumerate all of them and undesirable to do so here even if it were possible. It is customary to distinguish between types of unemployment, each type being thought of as representing a broad and general set of causes. Classifications by types are numerous, and each reflects the particular interests of the person making it. Here we shall distinguish five main types, not pretending that the classification is complete or that it is the best that could be devised.

Personal. Considerable unemployment results from what may be called personal causes. Many workers deliberately quit their jobs, some in order to accept or seek better or different ones at home or elsewhere, although in many cases the quit results from friction between employer and worker or between workers. Workers on strike are not generally classed as unemployed, although in some jurisdictions they are under certain conditions permitted to draw unemployment compensation benefits. Some workers are discharged for inefficiency or misconduct, connected with their work or otherwise, or for other personal reasons.

Until 1929 a very large proportion of separations, over 70 percent, were voluntary quits; for 10 years after 1929 the proportion of voluntary quits drastically declined, and layoffs and discharges exceeded 70 percent of all separations. As business conditions improve, the proportion of quits increases. Much of personal unemployment is concentrated among a relatively small part, from a fourth to a third, and usually among the least skilled part, of the working force. There are also some persons who work sporadically as a matter of preference.

The total volume of personal unemployment is not large, and what is more important the duration for any one individual is not usually long. Some of it is distinctly bad, but on the whole personal unemployment, as described here, represents the operation of healthy forces in our economy.

Frictional. In a large, integrated, and dynamic economy, many maladjustments, not cyclical in character, develop in the process of production and distribution. Many business organizations fail because of incompetent management, lack of capital, or for other reasons. Others consolidate, although not always because they are in difficulty. Marketing strategy, such as the introduction of style changes in automobiles, plays an important role in the process of competition for business, but it entails adjustments in production processes, changes that frequently interrupt production for some time. On the other hand, consumer resistance to some prices develops at times and this also affects the productive process.

There is considerable irregularity in some activities, as for example in loading and unloading ships. Arrivals and departures cannot be scheduled exactly in point of time. Some of this irregularity is attributable to natural phenomena such as storms and changes in temperature, some to unpredictable deficiencies in men, machines, or materials. For one reason or another, some prices get "out of line," occasioning curtailment or expansion in various parts of the economy.

Strikes may be considered as a frictional phenomenon. Strikes not infrequently result in restricted operations in other parts of the economy, especially when they occur in basic industries such as coal, steel, and railroads.

These, and many other, maladjustments may be thought of as frictions involved in the operation of the economy. They result in unemployment, which is commonly referred to as frictional unemployment. The extent of frictional unemployment is not known, but always there is a substantial amount of it, and it varies from time to time.

For this there is no real cure. Scientific management can reduce the extent of maladjustment somewhat, as can a more adequate organization of our labor placement system. But nature and human frailty cannot be eliminated, and competition, whether it be in the form of employers competing for markets or workers competing for wages and working conditions, is a healthy force in the economy.

Seasonal. Seasonal factors cause a considerable amount of unemployment, some of it total, some of it partial, but just how much is not known. Nearly every important industry experiences marked seasonal fluctuations. Coal mining, construction, the manufacture of automobiles and clothing, and transportation may be offered as ex-

amples. Seasonal unemployment exists in these and other industries because all, or nearly all, of the workers in them are attached regularly and permanently to those industries and remain attached during seasonally slack periods. Some workers do find other employment during slack periods, but many do not, either because the industry is located in industrially "isolated" areas, such as coal mining, or because their skills are not useful in other industries, as in the garment trades, or because the season is short and they prefer to sit it out.

As a rule, periods of seasonal unemployment are predictable and most of them are relatively brief. It is fair to say that seasonal unemployment does not generally present an acute problem, although it is not by any means unimportant.²² Seasonal unemployment becomes important when the question of compensating it arises, and it may well seriously damage an otherwise well-balanced unemployment compensation system.

There are some industries with seasonal fluctuations that may be said to result in employment rather than in unemployment. Much canning of vegetables, for example, is done during a few months in spring and summer. A substantial part of the labor force used is not normally dependent upon the industry for a living, but is made up for the most part of workers normally attached elsewhere, such as housewives and schoolchildren. Agriculture to a considerable extent employs during seasonal peaks workers who are not normally attached to it, as in harvesting grains and potatoes. Trade offers a considerable amount of such seasonal employment, not only during the rush Christmas period, but more or less regularly on Fridays and Saturdays and on "sales" days. Industries and occupations of this type do not present a serious problem of seasonal unemployment.

There is no good cure for seasonal unemployment, although there are palliatives. The two major proposed remedies are production for stock and "dovetailing" of products. It is obviously possible to produce most things for stock, including ice and electricity, but what is not so obvious is that the cost would be great, probably so great as to make it not worth while. Coal, for example, can be stored in spring and summer, but at an appreciable cost. The cost could be lowered if in off seasons operators were willing to produce for less,

²² See W. S. Woytinski, *Seasonal Variations in Employment in the United States*, Social Science Research Council, 1939, p. 71.

but they will not; workers will not accept lower wages; railroads will not haul the coal for less; and dealers will not appreciably reduce their profit margins. Operators storing coal would have to be protected against "snow-bird" operators who produce only during the months of high demand. In effect the industry would have to be cartelized and policed. If the "style" element found in so many goods we consume were largely eliminated or rigorously controlled, the problem would be simplified in some trades. It is possible in some instances to reduce seasonal unemployment by changing methods of production or distribution, but this procedure has serious limitations.

Dovetailing of products or employment also has exceedingly limited possibilities, but more than have been realized to date. It is possible for one firm to sell ice and coal, or to manufacture ready-made and bench-made clothes, or to have a variety of products with different seasonal peaks. Employers in a given community may work out a plan whereby they transfer workmen among themselves. And there could be dovetailing in various other ways. But only the ablest employers can or will do that. Furthermore, such actions not infrequently add instability to the employment of other producers who specialize in those products.

A third line of attack has recently assumed some importance. It is argued that wherever natural causes make it impossible to avoid seasonal fluctuations in employment, a system of guaranteed annual wages would at least reduce or eliminate concomitant fluctuations in income.²³ There seems to be but little doubt among economists that many industries could thus substantially mitigate the adverse effects of seasonal unemployment. But there is considerable doubt as to whether a widespread use of such plans would seriously affect the economy, and many able economists believe that on balance a comprehensive system of guaranteed wages would not be good.²⁴ Here again, the remedy is probably worse than the evil.

Technological. There is no dispute as to the existence of technological unemployment, but much dispute as to its extent and duration. Common observation confirms the claim that new and

²³ See Murray W. Latimer, *Guaranteed Wages, A Report to the President*, Government Printing Office, 1947.

²⁴ *Ibid*, comments by Professors J. M. Clark, Sumner H. Slichter, and Edward S. Mason, pp. 464-473, also A. D. H. Kaplan, *The Guarantee of Annual Wages*, The Brookings Institution, 1947, chaps. vii and viii.

more machinery, new and improved processes, generally result in the loss of jobs by many workers. When an industry decays because technological developments have made available more attractive, more useful, or cheaper competing commodities or services, or shifts to a new locality for some reason, stagnant pools of labor remain for years to burden the community.

But common observation usually both begins and ends at that point in the process. What preceded the innovations and what follows them in the industry in which they occur and in other industries is not easily subject to common observation. For in any large industrial economy, the forces affecting employment are numerous and varying in strength and their influences are so intermingled and intertwined that it is generally difficult to evaluate the relative importance of any one of them. There is no laboratory in which one force may be varied and all others held constant.

We are not here concerned with the theory of technological unemployment, but we cannot resist the luxury of making a few general observations. The volume of technological unemployment will vary with the extent of improvements being made, but not necessarily in the same proportion. The more technological improvements there are in any period of time, the greater will be the volume of technological unemployment or the higher the level of living. Technological improvements set in motion forces which lead to the employment of workers, either in the industry concerned or in other industries, or in both. Some of these workers, it should be noted, are employed before the improvements are introduced into industry.

The absolute volume of technological unemployment may constantly increase, but only if the total population gainfully employed or the extent of industrialization constantly increases, and the relative volume, that is the percentage of technologically unemployed to the total in the labor force, will increase only if and as the rate of technological improvement increases. The rate of technological improvement has never steadily increased except for very brief periods of time and indeed could not possibly increase markedly for a long period of years.

"Permanent" technological unemployment exists only in the sense that in a dynamic economy there are always some workers who are unemployed because of improvements. It is true that some individuals who lose their jobs because of technological improvements never get another one because they are too old, but that is not what

is usually meant by "permanent" unemployment. Frequently, but not usually, workers who lose their jobs because of technological improvements later find jobs in which their earnings are higher than before, but most of the displaced workers who find new jobs receive less pay.

Any "remedy" for technological unemployment would involve enlightened control over the introduction of improvements or over employment. That control could hardly be exercised except in a thoroughly monopolized or totalitarian economy, and it is not certain that it would be exercised effectively there. It would more likely be exercised in a monopolized than in a totalitarian economy, for monopolies are definitely interested in restricting production and it may reasonably be assumed that totalitarian societies are interested in increasing production. A totalitarian government could force workers to move from one industry or locality to another or could "make work" enough to absorb residual pools of immobiles.

The evils of technological unemployment may be great, but the cure appears to be drastic. One may well hesitate to accept the cure. Even an appreciable mitigation of the evil would involve a high price, in freedom or in the levels of living of those who benefit by improvements, or in both. The cost of control can be spread over time and among consumers, but it must be borne in any type of economy.

Cyclical. Business depressions and recessions are the most serious cause of unemployment. The number of workers who lose their jobs or are laid off during downward swings of the business cycle is always great and what is even more important the duration of cyclical unemployment is generally quite long. Data given above indicate the amount and duration of cyclical unemployment. Data presented to the Temporary National Economic Committee by Mr. Isador Lubin, U. S. Commissioner of Labor Statistics at that time, show that assuming 1929 prices and production would have continued the loss of national income from 1930 to 1938 inclusive was \$132.6 billion.²⁵ The national income in 1929 was estimated at \$81.1 billion. A substantial part of that loss merely represents dollar deflation. But the physical industrial production loss during those years amounted to nearly 140 percent of that for 1929, although the

²⁵ Bureau of National Affairs, *Verbatim Report of the Temporary National Economic Committee*, vol. i, Reference Data, Section III.

decline in the production of agriculture was negligible. The cost in terms of physical production was certainly great, although less than commonly believed. It was the concentration of unemployment among wage and salary earners, mainly wage earners, that was alarming.

Many remedies to cure us of business cycles have been proposed, the particular concoction depending on the social, political, and economic outlook of the prescriber. We are not here concerned with those remedies. Yet the following observations, or opinions, will be hazarded.

The business cycle is inherent in the functioning of capitalistic democracies, although we are not agreed as to just why that should be true. It may be mitigated by one or more small countries strategically located in the world economy, as in Sweden, for example, but only at the expense of other countries. To eliminate or appreciably mitigate the business cycle in any large economy, rigorous control of private initiative will be necessary. That means a planned economy. Any effective planned economy is incompatible with freedom of enterprise, which is the most essential element in capitalism. Thus if depressional unemployment can be eliminated or even appreciably reduced, it can be done only in a totalitarian or cartelized society. The evidence available at present does not justify the conclusion that even a totalitarian society actually can eliminate depressional unemployment, although it can hide unemployment rather effectively. But granting for the sake of the argument only that it could and admitting that depressional unemployment is exceedingly bad, yet one can reasonably choose the unemployment as the lesser of the two evils. Something can be done to alleviate the suffering of depressional unemployment, but nothing can relieve the curse of totalitarianism.

Effects of Unemployment. It has been suggested above that personal unemployment reflects in large part the operation of healthy forces in our economy and country. The movement of workers from one job to another, from one employer to another, from one industry to another, and from one locality to another helps bring about a better adjustment between workers and jobs than would otherwise exist. Some of that movement is quite aimless, just as lack of movement on the part of some people is quite senseless. But aimless movement and senseless nonmovement represent a part of the price we pay for freedom. The gain far exceeds the loss.

Technological unemployment also represents the operation of healthy forces in the economy. More people have been able to live, and to live on a higher plane, because of technological improvements. The resulting unemployment represents a part of the price paid for those improvements. It is the opinion of most economists that this part of the price is relatively small. Technology has made the economy more highly specialized, interdependent, and more subject to damage from shocks resulting from such things as crop failures, wars, and speculation. This also is part of the price we pay. There are some who believe that technological changes play an important role in bringing about depressions, and an elaborate theory, but one not generally accepted by economists, has been built up on the basis of this supposed relationship.

As suggested above seasonal unemployment does not present an acute problem since much of it is of short duration and is for the most part predictable.

But the excessive and prolonged unemployment resulting from, or at least associated with, business cycles, is for the most part distinctly bad. The income and savings of workers are reduced and many find it necessary to contract debts. Many families are broken up altogether, and in others the members are separated, at least for some time. Children are deprived of the opportunity for education, and young people who have finished their schooling are deprived of the opportunity for promotion in their chosen fields of work. Large numbers are compelled to accept relief, with unfortunate effects on their morale and on that of their families. Some, but fewer than popularly supposed, are so broken in spirit that they prefer relief to work. The seriousness of this phenomenon of unemployability is grossly exaggerated by both radicals and reactionaries. Unused skills do deteriorate, but the extent to which this occurs is also grossly exaggerated. Many who do not go on relief nevertheless suffer anguish and drastic reductions in their standards of living. Many suffer from lack of adequate or proper food. Honesty becomes for many a luxury which they think they can ill afford. Quacks become more numerous and suck too much of the little life blood remaining, and in return give only glowing promises of a better life to come, if only their panaceas be accepted. Governments are corrupted, partly in order to offset the growing influence of the quacks and partly because a portion of the increased flow of relief money just naturally fails to continue through the sticky fingers of some politicians.

More could be told, but it need not, for surely every reasonable and observant person is aware of the serious evils of prolonged unemployment. However, two observations may be hazarded. It is not true that "every part of the community loses when high employment is not maintained."²⁶ When high employment is accompanied by high costs and prices, some gain at the expense of others. Millions of individuals, most of them workers, are better off during depressions than during times of prosperity. That was true even during the great depression of the Thirties. For some had full and many others had nearly full employment at wage rates which were reduced less than the fall in prices. Their real wages were higher. During the postwar boom, with its full employment and high prices, the real income of millions declined. That is not, however, a good argument in favor of depressions, and it is not intended as such. It is a simple statement of a well-known fact.

The other observation is that drastic reforms might well involve a greater cost over a period of years than the evils that would be eliminated. Unemployment is a grievous burden when it occurs. But the economy in which it occurs may be more efficient over a period of years than one in which unemployment is eliminated by rigorous controls. It may be more efficient in terms of quantities and qualities of goods and services produced. And it does provide more freedom for individuals of all classes, and freedom is a valuable good, perhaps the most valuable, even in times of depression. This observation will not be considered seriously by those starry-eyed dreamers who, having read a book, consider themselves properly qualified to roll up their sleeves and make over the world.

UNEMPLOYMENT COMPENSATION

Unemployment compensation is not in any sense of the word a panacea for the evils that have just been suggested. Even its most ardent advocates know that. It is not designed to alter in any fundamental respect the existing system of production and distribution. There are some, it is true, who believe that unemployment compensation can be made to bring about a greater degree of stabilization in business. But this is disputed by others, and in any event it is not contended that unemployment compensation alone is sufficient to

²⁶ Murray W. Latimer, *Guaranteed Wages, A Report to the President*, 1947, p. 20.

eliminate, or to appreciably mitigate, the business cycle. Certainly none of its advocates contend that compensation will eliminate private enterprise and the profit system, although some of its opponents have advanced that suggestion.

What then is unemployment compensation designed to do? As a first approach to an answer, it may be said that unemployment compensation is designed to distribute part of the money losses that are suffered by workers because of unemployment. Not all unemployment is paid for, and what is compensated is at less than the full amount lost, especially for the better-paid workers. The duration of benefits in even the most liberal system is not long enough to care for extended unemployment. In short, it may be said that unemployment compensation is designed to distribute in part the losses suffered from erratic unemployment and to absorb the first blow of depressional unemployment. There is reason to believe that seasonal unemployment results in a disproportionate amount of payments made. As presently designed, the relief of prolonged unemployment falls altogether outside its scope.

The cost of paying benefits is distributed. Just who bears the burden, whether it be the workers, employers, or public, or all combined, is disputed. But the burden is not borne by the unemployed worker who receives benefits, except to the extent that he as a worker or a consumer may pay the necessary taxes.

CHAPTER TEN

FEDERAL UNEMPLOYMENT COMPENSATION PROVISIONS

As in other countries and with other movements, unemployment compensation in the United States is rooted in the past. But before Federal action was undertaken to speed the movement along, we had only mere rootlets that were not very firmly imbedded in our economy. As a result of Federal action, the country was blanketed with state laws within the space of a few years. It will be worth while to review briefly the background to that action.

THE BACKGROUND

The high lights of that background include the abandonment of an ancient concept, the testing of voluntary plans, and the struggle, through prosperity and adversity, for compulsory acts.¹

Poor Relief. Until about 1890, unemployment was in this country regarded as a problem of poverty and poor relief. Almshouses were well patronized by tramps, and vagrancy and unemployment were considered to be almost synonymous. Unemployment was thought to be the result of personal causes, a conclusion which arose from the hardy American doctrine of individualism. However, the English, where the doctrine of individualism was less hardy, held the same belief. By 1900 it had become clear to social scientists and business leaders that there were important nonpersonal causes of unemployment, such as business depressions, seasonal fluctuations, new inventions and processes, bankruptcies and mergers; and by 1910 the idea that unemployment was primarily "a problem of in-

¹ The material in this section is taken in modified form from the author's chapter, "Minimum Income Insurance," in Seba Eldridge and associates, *Development of Collective Enterprise*, University of Kansas Press, 1943.

dustry" was generally accepted. The report of the British Poor Law Commission, 1906-1909, and Mr. (now Sir) William Beveridge's book: *Unemployment, a Problem of Industry*, published in 1908, were perhaps mainly responsible for the shift in opinion, or at least for its crystallization, but the depressions of 1897 and 1907 contributed materially to a better understanding of the problem.

So long as unemployment was considered to be primarily the result of personal causes, the workhouse test was the only remedy considered applicable. As understanding of the phenomenon increased, other remedies were proposed, such as the stabilization of industry, public works, placement offices, vocational training, restriction of immigration, and reduction of hours. These new remedies were proposed by students of the social sciences and trade union officials. Some writers were interested in the possibilities of insurance against unemployment, but they were few and exercised little influence.

Trade Union Benefit Plans. English trade unions began paying out-of-work benefits early in their history, and the first American example of which there is a record dates back to 1831.² In America, trade unions had the only systematic provision for unemployment until after 1914, except for one guaranteed employment plan established in 1894 in the wallpaper industry and sponsored jointly by a union and an employer. But the movement was decidedly backward, owing to weakness of the union movement, to the idea that unemployment was due to personal causes, to opportunities for personal advancement, and to the belief prevalent after World War I that business could be stabilized.³

The city of Ghent, Belgium, in 1900 began the policy of subsidizing private organizations, mostly unions, paying unemployment benefits. The Ghent system, as it has come to be known, was widely adopted in other European cities, and it became the first type of unemployment compensation to gain substantial popularity. In the United States, however, the idea, while exerting some influence, never became very popular. As late as 1910, a prominent and socially-minded American economist believed that it would be "premature" to propose the Ghent system for this country, and he

² Bryce M. Stewart and others, *Unemployment Benefits in the United States*, Industrial Relations Counselors, Inc., 1930, p. 80.

³ Constance A. Kiehel, "Security of Job Tenure and Trade Union Benefits," *American Economic Review*, September 1937, pp. 453-455.

recommended instead that the Federal government encourage trade unions to pay benefits by informing them of the methods used by unions in other countries.⁴ A New York commission appointed in 1909 to study employers' liability and other matters reported in 1911 the conclusion of its subcommittee, to which W. M. Leiserson was attached as a special investigator, that although unemployment insurance was commendable, Belgium could not be emulated here until adequate data became available.

Early Movement for Compulsory Acts. Britain enacted a compulsory unemployment insurance law in 1911, to become effective the following year. The Poor Law Commission, which reported in 1909, was divided in opinion on the subject, but both the majority and the minority groups were opposed to a compulsory act. The Charity Organization Society, the insurance companies, and the trade unions were also opposed. But Winston Churchill, then president of the Board of Trade, was desirous of having some kind of a national system, and he asked Hubert Llewellyn Smith and William Beveridge to prepare a plan that would provide payments not tainted with charity. They did so. Lloyd George, the Chancellor of the Exchequer, the "little Welsh attorney" with a social imagination and burning eloquence, fought brilliantly for that plan and despite widespread opposition succeeded in bringing about the enactment of the world's first compulsory national unemployment insurance law. The Act did not become popular in Britain, however, until after the first World War.⁵

The British act stimulated interest in the United States, but the movement here remained feeble. The American Association for Labor Legislation, until 1927 the only national organization advocating social security measures and the most potent factor in the early unemployment compensation movement, sponsored the American Conference on Social Insurance, which in 1914 urged the adoption

⁴ Henry Rogers Seager, *Social Insurance*, The Macmillan Company, 1910, pp. 111-112. Professor Seager discussed the Ghent system at the first annual meeting of the American Association for Labor Legislation in 1907.

⁵ Mary B. Gilson, *Unemployment Insurance in Great Britain*, Industrial Relations Counselors, Inc., 1931, pp. 40-41, R. C. Davidson, *The Unemployed*, Longmans, Green & Company, Inc., 1929, chap. 11. The Liberal Party Ministry had promised the electorate that if it were returned to power it would provide unemployment insurance covering at least 2,500,000 persons. That was approximately the number of trade unionists and it was supposed by many that the Ghent system would be introduced. Henry R. Seager, *Social Insurance*, 1910, p. 110.

of unemployment insurance. Late in 1914, the California Commission on Immigration and Housing favored unemployment insurance, but was not prepared to recommend any particular form. A few days later the Chicago Municipal Markets Commission, reporting to the Mayor and Aldermen on a practical plan to relieve destitution and unemployment, spoke favorably of insurance. Various attempts to permit authorized insurance carriers to underwrite unemployment insurance failed.

A bill modeled after the British act, but including a wider range of industries, was drafted by the American Association for Labor Legislation for the Massachusetts Committee on Unemployment and introduced in the Massachusetts legislature in January of 1916. That was the first American unemployment compensation bill. In the hearings, the bill was opposed by representatives of employers' and employees' organizations and it did not come to a vote.⁶ War-induced prosperity killed nearly all interest in it. The Massachusetts legislature of 1916 created a committee on social insurance, and a minority report of that committee made early in 1917 advocated "some system" of unemployment insurance whenever adequate data became available.

Representative Meyer London, Socialist, introduced in the Congress in 1916 a resolution to create a commission to draft a bill for a national system, and this was the first time the subject came before the Congress. In the hearings, unemployment insurance was advocated by Rufus M. Potts, an insurance executive, and by Dr. I. M. Rubinow, secretary of the insurance committee of the American Medical Association, who appeared at the request of the Socialist Party. Samuel Gompers, of the American Federation of Labor, opposed a commission to study compulsory insurance, but was willing to have a commission study voluntary insurance.⁷ Nothing more was done in Congress on the subject for twelve years, when a bill introduced by Representative Victor Berger, also a Socialist, was killed by the Committee on Judiciary and the Senate Committee on Education and Labor undertook the first study of the subject made by a Congressional committee. The Socialist activity mentioned here had little influence on the movement and that probably of an adverse sort. Any proposal by a Socialist was certain to fail of passage and to stiffen the opposition.

⁶ Bryce M. Stewart, *op. cit.*, p. 574.

⁷ *Ibid*, pp 570-571

The depression of 1920, with its peak of unemployment of about 4,250,000 nonagricultural workers, revived interest in unemployment compensation. It did so despite President Harding and Secretary Hoover's warning to the members of the President's Conference on Unemployment against the dangers of "doles from the public treasury." The Huber bill, best known and most important of early state bills, was introduced in the 1921 session of the Wisconsin Legislature. Professor John R. Commons was responsible for the form of that bill. Following the principle of workmen's compensation, the bill placed the entire cost on employers. A state-wide pooled fund was established, and rate variations based on the volume of unemployment were allowed. It was a blend of workmen's compensation and unemployment insurance, hence the name "unemployment compensation."⁸ The bill came within one vote of passing. Similar bills were introduced in the 1921 session of the Pennsylvania legislature, in the 1923, 1925, and 1927 sessions of the Minnesota legislature, and in several sessions of the New York legislature in the 1920's. All of these bills were supported by organized labor and opposed by employers' organizations. A Socialist representative introduced a bill modeled after the English law in the 1921 session of the New York legislature.

Early in January of 1922, Henry L. Shattuck introduced an unemployment insurance bill in the Massachusetts House of Representatives. In the hearings, the bill was supported only by Henry L. Dennison, liberal manufacturer, and by John B. Andrews, secretary of the American Association for Labor Legislation. It was opposed by the Massachusetts Associated Industries and by representatives of the American Federation of Labor. A committee to which the bill was referred reported adversely, saying that compulsory unemployment insurance was inconsistent with American principles and that, if adopted, the state's industries would be at a competitive disadvantage.

The "New Era" and Voluntary Plans. The "new era" of prosperity in the middle and late Twenties saw the movement lag and almost die out. It was believed that there was no need for such legislation. England's unfortunate experience with the "dole" was fully exploited by those opposed to unemployment insurance. It is true that in Wisconsin a bill was regularly introduced and that a

⁸ Edwin E. Witte, "Development of Unemployment Compensation," *Yale Law Journal*, vol. 55, No. 1, December 1945, p. 24

few bills were introduced in other legislatures as well, especially in New York. It is true also that in 1928 Senator Couzens succeeded in getting an investigation of the subject made by the Senate Committee on Education and Labor, which reported that to establish such a system would be "premature." There was considerable progress in the movement for voluntary plans among employers, and also joint union-employer plans, and a decline in union out-of-work benefits. But it all added up to very little. Bryce M. Stewart could say that "the charity approach" still remained dominant.

A survey made by the United States Bureau of Labor Statistics in April of 1931 showed 79 unemployment benefit or employment guarantee plans in establishments employing about 226,000 workers, although at least 65,000 of those were not eligible for benefits.⁹ There were 15 employer plans in establishments employing 116,000, although only about 50,000 were eligible for benefits. The first of these was established by the Dennison Manufacturing Company in 1916, but benefits were not payable until 1920. The Columbia Conserve Company established its plan in April of 1917, and it is generally credited with being the first to pay benefits. All but three of the plans were established before the Great Depression. There were 16 union-employer plans covering 65,000 workers. The first joint plan was set up in the wallpaper industry in 1894, and it stood alone until 1921 when a plan was organized for the women's clothing industry of Cleveland, Ohio. The most famous of the joint plans was that in the Chicago men's clothing industry, which was set up by Professor John R. Commons. The only joint plan established after 1928 was in the hosiery industry in 1930. In 1934, the number of plans had declined to five. Forty-eight trade union plans, all but three of which were by local unions, covered some 45,000 workers. The oldest was that set up by the Deutsch-Amerikanische Typographia in 1884. Seventeen were established before 1920; 20 in the years 1920-1928; and 11 after 1928, eight of these after the depression started in 1929.

The Great Depression. During the Great Depression, America experienced its most extensive and prolonged unemployment. As a result, interest in unemployment compensation increased greatly. Bills to establish compulsory state plans were introduced in 17

⁹ United States Bureau of Labor Statistics, *Unemployment Benefit Plans in the United States and Unemployment Insurance in Foreign Countries*, Bulletin No. 544, 1931.

legislatures in 1931. In 1932 the Democratic national platform contained a plank favoring state unemployment insurance laws, the American Federation of Labor reversed its traditional opposition and approved such legislation, and Wisconsin enacted America's first unemployment compensation law. That law embodied the "employer-reserve" principle, and was to become effective only if an insufficient number of voluntary plans were established within a reasonable time.

A veritable flood of bills flowed through the 1933 and 1934 state legislatures, but none was enacted into law. In a few states, one house passed a bill, but Professor Witte says that in 1933 Wisconsin would have repealed its law had its supporters not agreed to postpone the effective date for another year. Two reasons were offered by the successful opposition: first that the added burden on business at the time would hinder recovery; and second that any state enacting a compensation law would put its employers at a competitive disadvantage.

A United States Senate committee appointed early in 1931 to investigate unemployment insurance concluded that such insurance was not within the sphere of Congressional action and that if it were it would be inadvisable, but that Congress could encourage private systems by allowing employers to deduct all or part of their contributions in computing their income taxes. Senator Wagner, a member of the committee, urged compulsory state laws and Federal income-tax deductions, but he did not at that time urge the tax-offset method later adopted.

In 1934 the Wagner-Lewis bill to encourage state action proposed a Federal tax with provision for offsetting state taxes. All groups advocating unemployment insurance were agreed on this proposal. President Roosevelt urged its passage in a letter to the Ways and Means Committee. Lawyers were convinced that such an approach would stand a good chance of Supreme Court approval and also would be most likely to secure the approval of influential state authorities. The bill was not reported out of committee. Instead, President Roosevelt and his Cabinet committed themselves, in his special message to Congress on June 8, 1934, to a thorough study not only of unemployment insurance, but of all aspects of social security, with the further promise that he would present a comprehensive social security bill to the next Congress. The reason for the

delay seems to have been that the leaders believed the time for a fairly comprehensive system of social insurance was at hand and that hasty movement in any one direction was likely to interfere with the establishment of a well balanced system.¹⁰

A fairly comprehensive plan including unemployment compensation was worked out in 1934. For unemployment compensation, the Committee on Economic Security did not recommend a national system as it had for old-age insurance. It proposed instead state systems. Action by the Federal government should consist of legislation enabling states to act, safeguarding reserve funds, and assisting the states with their problems, but leaving to the states the primary responsibility for administration. Since the greatest obstacle to state enactments apparently was fear of competitive disadvantage, the Committee recommended a uniform Federal tax on pay rolls with the privilege of an offset against that tax to employers in states having unemployment compensation laws. Fear of unconstitutionality was an important factor in the Committee's preference for the tax-offset plan rather than a national system or a tax-rebate plan, but the presence in strategic positions of persons responsible for the Wisconsin employer-reserve plan was also a factor of importance.

President Roosevelt used all of his influence to get Congress to enact the bill, and he was successful, although many changes were made in the basic bill agreed upon by the Committee on Economic Security. It was the Social Security Act that resulted in the establishment of unemployment compensation programs in all of the states.

THE SOCIAL SECURITY ACT PROVISIONS

The Social Security Act of 1935 provided, among other things, for stimulating the enactment of state unemployment compensation laws. A Federal Unemployment Tax was levied on pay rolls and employers paying taxes under an approved state unemployment compensation law were authorized to offset those payments, up to a specified maximum, against the Federal tax. Provision was also made for paying out of Federal money all necessary and proper costs of administering the state laws. That was done in order to

¹⁰ Edwin E. Witte, "An Historical Account of Unemployment Insurance in the Social Security Act," *Law and Contemporary Problems*, vol. iii, 1936, pp. 157-169.

insure that adequate administrative machinery would be established by the states. But the matter of insuring that state laws would be reasonably adequate was for the most part side-stepped, and states were given almost complete freedom to experiment and to adapt their laws to local characteristics. Only a few general conditions were laid down, the observance of which was required for approval.

The Federal Tax. An unemployment tax of 3 percent is levied on the wages and salaries paid by those who employ eight or more different individuals on any 20 or more days in the calendar year, each day being in a different week, but the tax is not levied on that part of any worker's wage which exceeds \$3000 per year from any one employer. Thus an employer who has eight different workers on at least one day in each of 20 weeks and seven or fewer for the remainder of the year pays the tax on the wages of all of his workers for the entire year, and not only on the wages of the eight, or for 20 weeks. In 1954, Congress provided that beginning on January 1, 1956, the tax applies to employers of four or more.

The rate of 3 percent was chosen partly because studies made indicated that 3 percent of pay roll would have yielded enough money to pay the benefits provided in model bills throughout the 1920's and into the year 1932, including the cost of administration. It also represents a compromise between those who wanted high benefits for large numbers and those who wanted to restrict the system to disaster relief. Employers of fewer than eight were not included because it was thought that the problem of administration would be too complex until after considerable experience had been accumulated, and also in order to keep down political opposition. The minimum of 20 weeks was inserted to eliminate purely seasonal activities closely connected with agriculture.

As first enacted in 1935, the tax was on total wages, but in 1939 the limit of \$3000 was adopted because it was thought that the relation between the tax and possible benefits to employees with high incomes was too much out of line. Furthermore, payments made to or on behalf of a worker under retirement, sickness or accident disability, medical or hospitalization, or life insurance plans are not taxed, provided the worker does not have the option of receiving the equivalent of the premiums in lieu of the insurance, or of assigning life insurance benefits, or of receiving a cash value upon withdrawal from the plan.

Employments Excepted. The tax is not levied on all employment. Until 1950, exclusions were practically identical with those in the Old-Age and Survivors Act, but since then coverage under the latter Act has expanded greatly while practically no expansion has occurred in the unemployment tax coverage. The most important of the excluded employments are agriculture, domestic service, casual labor, public service whether governmental or proprietary, and work for religious, charitable, scientific, literary or educational organizations not operated for profit. There is now a separate Federal act for interstate transportation employees and therefore the tax no longer applies to them. In the original act, interstate transportation was included and the employees were covered by state acts. A separate system was established at the insistence of the railroad workers, and there was but little serious opposition from any source.

Tax Offset. Employers subject to the Federal tax who are also required to pay a state unemployment compensation tax may deduct from their Federal unemployment tax the amounts they actually pay to the state, subject however to certain conditions. No matter how much an employer pays to the state, he may not deduct more than 90 percent of his Federal tax. It was believed that 10 percent of the 3 percent tax would suffice to pay all necessary administrative costs. And no employer may deduct from his Federal tax what he pays into the state unless the state act is approved by the Secretary of Labor. The following general requirements specified in the Federal law must be incorporated into state acts if they are to be approved for tax-offset purposes.

No state act could be approved originally unless it provided that benefits would not be payable for at least two years from the first day on which contributions to the state fund became payable. This was done to enable the states to build up reserves against which to draw if necessary once their acts became fully operative.

All the money collected by the state must be sent to the Secretary of the Treasury, who puts it in what is called the Unemployment Trust Fund. This was done to make possible centralized investment of reserves and to protect those reserves. A separate book account is maintained for each state and amounts received, plus interest earned on those amounts, are credited to the accounts of the states making them.

The Secretary of the Treasury keeps in cash as much of this Fund

as he thinks necessary to meet current withdrawals by states, and invests the remainder in United States bonds, or in obligations the principal and interest of which are guaranteed by the U.S. Government. The obligations may be bought in the open market, or they may be original issues at par. Special issues of bonds made for this purpose bear interest at a rate equal to the average rate of interest borne by all outstanding interest-bearing obligations then forming a part of the national debt. Obligations other than these special issues may be purchased only if they yield at least as much as do the special issues. The Secretary may sell any obligations so acquired when necessary to meet current withdrawals, and he may redeem special issues at par. Interest earned is added periodically to the Fund and becomes a part of the reserve.

A state may draw on its account in the Unemployment Trust Fund, but it may draw only what is needed to pay benefits to unemployed workers, and in no case more than it has to its credit. Strictly speaking, the money may be withdrawn and used for any purpose whatsoever. But if used for any purpose other than the payment of benefits, the tax offset and "additional credits" would no longer be available to employers. In 1946 this limitation was amended to permit states in which employees have contributed to the Fund to withdraw the amounts contributed by employees in order to pay cash disability benefits, but not to pay the expenses of administering disability compensation. Nine states have at one time or another collected contributions from employees for unemployment compensation, and three for cash disability payments. Furthermore, all benefits must be paid by the state through public employment offices, or through such other agencies as may be approved by the Secretary of Labor. Many states pay by checks mailed through the postal system.

Another condition is important. Unemployment compensation acts are designed to pay benefits to persons out of work, able to work, but unable to find a job. If work is available and an unemployed person refuses without good cause to accept it, he generally automatically becomes ineligible for benefits, at least for an extended period of time. However, the Federal Act specifies that no unemployed worker who is otherwise eligible shall be denied benefits because he refuses to accept a job if that job is available as the result of a strike, lockout, or other labor dispute; if the wages, hours, or working conditions are substantially less favorable than those pre-

vailing for similar work in the community; or if in order to get the job the worker must join a company union or sign a "yellow-dog" contract, i.e., give up membership in or promise not to join a bona fide union. These provisions were inserted to make sure that state unemployment compensation laws are not used as weapons to break strikes, weaken regular labor unions, or break down labor standards.

Finally, all the rights, privileges and immunities conferred by a state's unemployment compensation law must be subject to amendment or repeal by the state legislature. This condition was probably inserted to prevent contracts between workers and employers which could not subsequently be impaired by legislation, owing to the Federal constitutional provision prohibiting state legislation impairing the obligation of contract. Furthermore, it prevents an individual from acquiring a vested interest in promised benefits or tax rates.

These are the conditions which must be observed in state laws in order that employers may deduct from their Federal tax the amounts they actually pay under state unemployment compensation laws.

Additional Credits. In states having experience-rating plans many employers do not pay the "standard" tax rate, which is 90 percent of 3 percent, but pay less because they maintain relatively stable employment. The tax-offset credit allowed against the Federal Unemployment Tax applies only to the amount of tax actually paid into a state plan. Unless special provision is made, then, the employer who is charged less than the standard rate by the state would gain nothing, for he would have to pay the difference to the Federal government. That is why provision is made for allowing the employer an "additional" credit.

Additional credits amount simply to this, that employers whose taxes are reduced because their workers experience relatively little unemployment may deduct from their Federal tax not only the amounts actually paid into a state fund, but also the amounts that they would have paid had they been charged the highest rate applicable in the state. They may not, however, deduct more than 90 percent of the Federal tax. In order to prevent abuse of the privilege of additional credits, certain special conditions laid down by the Federal act must be incorporated into state acts.

In those states having pooled funds with experience rating, i.e., where all of the taxes go into a single state-wide fund, no employer

may be given a reduced rate except on the basis of his employment experience, or other factors bearing a direct relation to unemployment risk, for the three years immediately preceding the one in which he is to have the reduced rate. But beginning January 1, 1955, newly covered employers who have not been subject to the state law for three years may nevertheless get lower rates based on the experience they have accumulated under the law, but not with less than the entire year immediately preceding the computation date. Uniform rate reductions are not permitted, even though they might at times be desirable.

For employers in states having reserve account plans, i.e., where part or all of an employer's contributions are credited to his individual account and benefits are paid from that account to his workers, the conditions are more complicated. No reduced rate may be given to an employer unless: (1) benefits were payable from his reserve account throughout the entire preceding year; (2) the balance in his reserve account equals at least five times the largest amount of benefits paid from it in any one of the three preceding years; (3) that balance is not less than 2.5 percent of the pay roll on which taxes were paid into the reserve account during the three preceding years.

Minimum conditions are laid down in the Federal law which must be observed if employers guaranteeing work or pay are to have the benefit of lower unemployment compensation taxes for doing so. Special provision was at one time made in several state laws for guaranteed employment plans, and workers who in accordance with such plans would have received the amount of employment or wages guaranteed would not have been eligible for unemployment compensation benefits during the guaranteed period. However, no state ever put this optional provision into effect, and all such state provisions have been repealed.

Voluntary Contributions. Some state laws provide that employers who wish to do so may make voluntary contributions to their accounts in order to get the benefit of lower rates under the state experience-rating plan. Until 1947, the Federal law made no mention of such a procedure, but the Social Security Administration approved the practice, provided that the voluntary contributions were made before the first date in the year on which regular payments were due. However, early in 1947, Minnesota amended its unemployment compensation law to count voluntary contributions

made on or before June 30, 1947, or within 60 days thereafter, on rate reductions retroactively for the year 1946 and currently for the year 1947.

The Federal Commissioner for Social Security could find no reasonable basis under the Federal Act for approval of the amendment, and the result of his refusal to approve meant that Minnesota employers would not be permitted to deduct their additional credits from the Federal tax. But the Congress changed the law.¹¹ Voluntary contributions are now expressly permitted. Beginning with 1948, the contributions may be made at any time within 120 days of the beginning of the rate year. The law also permits voluntary contributions made before 1948 to be counted for rate making purposes.

Administrative Costs. The Federal government pays all the costs necessary and proper for the efficient administration of state acts, as certified by the Secretary of Labor, who now administers the law, to the Secretary of the Treasury, but the Federal government does not administer or supervise the administration of those acts. In computing the amounts to be paid for administration, the Secretary must consider the state's population, the estimated number of persons covered by the law, and such other factors as are believed to be relevant. But the Secretary may not certify for any fiscal year a total amount for all states greater than the amount appropriated for that year by Congress.

In order to qualify for this expense money, the state acts must conform to certain standards. There must be a merit system for the selection, compensation, and tenure of personnel administering the act. But the Secretary of Labor has absolutely no authority with respect to the selection, tenure, or compensation of any individual. Furthermore, there must be such methods of administration as are reasonably calculated to insure the full payment of benefits when due. All of the money paid to the states for administration must be used for that purpose.

In order to qualify for administrative expense grants, state acts must also provide an impartial tribunal before which any person who is denied benefits may have a fair hearing. All the money collected from the state unemployment tax must upon receipt be deposited in the Unemployment Trust Fund in Washington and withdrawn only to pay benefits, which are to be paid through public

¹¹ *Public Law No. 266, 1947. Social Security Bulletin*, September 1947, p 14.

employment offices or other agencies approved by the Secretary. However, the excess of Federal unemployment tax collections over grants for administrative expenses credited to state reserves may be used for benefits or administration. Amounts collected from workers by states may be used to pay temporary disability benefits.

The state must also make such reports as the Secretary of Labor may require, and he must also report upon request to any Federal agency administering public works or assistance programs the name, address, occupation, employment status, and rights to further benefits of persons receiving unemployment compensation. The object of this provision is to make possible some degree of coordination between the respective agencies. If the Secretary finds that any state administrative agency unjustly denies payments to qualified individuals in a substantial number of cases, or fails to comply with any of the provisions given above, administrative grants will cease and will be resumed again only after the Secretary is satisfied that corrective measures have been taken.

The Federal tax of 3 percent is uniform throughout the entire country, and all employers covered by the act are subject to it. Thus employers in a state without an unemployment compensation law would not have a competitive advantage over those in states with such a law, for they would have to pay as much, and in many instances even more, to the Federal government. Furthermore, their workers would not be eligible for benefits. Money is thus "kept at home" by having an unemployment compensation act. This "inducement," if such it can be called, has been so attractive that all states have enacted laws.

THE FEDERAL EMERGENCY RESERVE

The War Mobilization and Reconversion Act of 1944—the "George" law—established a Federal Unemployment Account in the Unemployment Trust Fund, which was designed to be a source of money for states whose reserves might be in danger of being depleted.¹² At the time this law was enacted, there was considerable fear that during the postwar reconversion to civilian production unemployment would reach excessive proportions in some states and exhaust reserves.

The Act authorized appropriations to this Account of (1) that

¹² *Public Law No. 458*, 78th Congress, approved October 3, 1944.

part of the Federal Unemployment Tax collected before July 1, 1943, which was in excess of the amount actually spent for administration of state acts; (2) any such excess existing in the fiscal year 1945 and subsequent fiscal years, and (3) any further sums that might be necessary to lend to states which found it necessary to borrow because of inadequate reserves. It was intended that this Account should be maintained only during the immediate postwar period; and although extended for a time, the Act was later amended to eliminate the authorization of any additional sums needed, and also to abolish the entire Account on April 1, 1952, with the amount in the Account returned to the general fund of the Treasury.

The amendments of 1954 reestablished the loan account. The excess of Federal collections from the three-tenths of one percent tax payable by covered employers over employment security administrative expenditures is now appropriated to the Unemployment Trust Fund. Employment security administrative expenditures are those made by the national government for administering state unemployment compensation acts, seamen's and veterans' unemployment benefits, expenses incurred by the Treasury in collecting the tax and by the Department of Labor in making the grants, and the cost of operating state public employment offices, which is paid by the Federal government. As much of the excess collections in any year as is needed to bring the loan fund up to a level of \$200 million and to maintain it at that figure is transferred to the loan fund, called the Federal Unemployment Account. Excess amounts collected since the system began, which were used by the national government for general purposes, are also appropriated, with some exceptions.

That portion of the excess not needed to reach or maintain the \$200 million level in the Federal account is credited to the state accounts in the Unemployment Trust Fund. Each state, unless for some reason it is ineligible to participate, is credited with the same proportion of the amount distributed as the ratio of its taxable payroll to the total taxable payrolls of all states combined. It will be recalled that in some states the payroll taxed is greater than the payroll subject to the Federal unemployment tax, as where the state law covers employers of one or more. If, for example, the taxable payroll of a given state's law for the year is \$300 million and the total of all taxable state payrolls is \$100 billion, then that state's payroll is equal to three-tenths of one percent of all taxable

state payrolls. If \$100 million is to be distributed, then that state's account in the Trust Fund will be credited with three-tenths of one percent of \$100 million, which is \$300,000.

The procedure for making loans is simple. If at the end of any calendar quarter the balance in a state's reserve account in the Unemployment Trust Fund is less than the amount of unemployment compensation benefits paid by the state during the 12 months ending with the close of that quarter, and if during the following quarter the Governor of the state applies to the Secretary of Labor for a loan, then the Secretary of Labor certifies to the Secretary of the Treasury the amount requested, which will be transferred to the state's account. But the maximum amount that will be loaned to a state is the highest total of benefits paid in any one of the four calendar quarters preceding the one in which the application was filed. No interest is charged on the loan.

The loan must be repaid. At the request of the Governor, amounts specified by him will be transferred from the state's account to the Federal account. There is provision for what amounts to forced repayment, not directly by the state but indirectly by its covered employers. During the year beginning with the fourth consecutive January 1 on which there is an unpaid balance, the "additional credits" which employers are allowed to deduct from the three percent Federal tax because of experience-rating provisions are reduced by five percent of the three percent tax, and by an additional five percent for each succeeding year in which an unpaid balance remains.

For example: an experience-rated employer with a taxable payroll of \$100,000 who would otherwise pay \$1000 to the state and \$300 to the Federal government would instead pay \$450 to the Federal government in the first penalty year. His additional credit of \$1700 otherwise allowable under the Federal law would be reduced by \$150. For each succeeding year his credit would be still further reduced, an additional five percent for each additional year, i.e., 10 percent for the second year, 15 percent for the third, and so on until the additional credit is all gone. The amounts collected attributable to reduced additional credit allowances are considered as sums advanced in repayment of the unpaid balance of the state's loan and are appropriated to the Federal account. A borrowing state may for some time continue to allow lower than standard taxes to its employers who have relatively stable employment, but it may not con-

tinue to do so indefinitely at the expense of the Federal Treasury. There is no way to compel repayment so long as the state's tax collections are insufficient to pay current benefits, if all covered employers are taxed at the rate of 2.7 percent, or more, of covered payroll.

The state's reserve in the Unemployment Trust Fund earns interest. But in computing the amount of interest to be credited to a state's reserve, the unpaid balance of any loan to bolster those reserves is deducted from the amount in the state's account. Nor is interest paid on amounts collected by reducing the additional credits otherwise allowable to employers in states with unpaid balances.

Should loans to states threaten to exhaust the Federal Unemployment Account, authorization exists for Congress to appropriate to that account as much money as is necessary to provide states with the loans they need and for which they qualify. In other words, benefits to workers will not cease in any state because that state's reserve has been used up, if the state is willing to borrow, and in a serious depression the Federal government would no doubt provide funds enough to bolster all state reserves.

The amount derived from the excess of collections under the Federal unemployment tax of three-tenths of one percent over employment security administrative expenditures and credited to the state accounts in the Unemployment Trust Fund is intended to be used primarily to pay unemployment benefits. However, some or all of it may be used by the states to meet those costs incurred in administering the state's act which are not paid by the Federal government, but only if certain conditions are met. The amount to be so spent from that excess must be appropriated by the state legislature, and the purposes for which the money is to be spent and the amounts authorized for each purpose must be specified in the law. Furthermore, the appropriation must limit the amount that can be spent during any one fiscal year to the difference between the total excess credited to the state during that fiscal year and the four immediately preceding ones and the amount used and charged to the state during those five years. Authority to make the expenditures must not extend for more than two years after the date on which the appropriation bill was enacted into law. Finally, the money must be withdrawn from the Trust Fund and spent after the date of enactment.

UNEMPLOYMENT COMPENSATION FOR FEDERAL EMPLOYEES

Until 1955, the protection provided by unemployment compensation laws was not available to employees of the Federal government. Federal employees could not be covered by state acts and there was not a separate national system for them. Provision was made in 1954 to extend that protection to them, beginning January 1, 1955.

Nearly all employees of the United States and its wholly owned instrumentalities are given this protection. Excluded are elected officials, members of the armed forces, foreign service personnel allowed special separation allowances, foreigners employed outside the United States, working inmates of Federal institutions, nurses and student employees in Federal hospitals, temporary emergency workers, workers on relief projects financed by the government, Federal maritime employees already covered by state acts, and a few other minor groups. The number included is approximately 4 million, and there are about half a million separations yearly. A substantial proportion of the separations are involuntary.

There is not a single national system applicable to all employees alike. Instead the service and wages of all included Federal employees are assigned to the states in which they had their last official station, i.e., in which they were working, prior to the filing of their first claim for compensation benefits. But if when a separated employee files he is living in another state where he also has Federal service, that is if he had transferred and was then separated, or if his service was outside the United States, his service and wages are assigned to the state in which he is residing when he files his first claim. Claimants residing in Puerto Rico or in the Virgin Islands who file their first claim while residing there are assigned to the District of Columbia.

Benefits are paid to unemployed Federal workers by the states to which their service and wages are assigned "in the same amount, on the same terms, and subject to the same conditions" as those paid by the states to other persons covered by their laws. This is done in accordance with agreements made between the Secretary of Labor and appropriate state officials or agencies. State determinations with respect to entitlement of Federal employees to benefits are subject to review in exactly the same way as are determinations made concerning other employees covered by the state law.

The amounts paid in benefits to Federal employees in accordance with state agreements are refunded to those states by the Federal government, out of money in the general fund. The cost is thus borne by the national government, which is the employer.

If there is no state agreement, benefits are paid by the Secretary of Labor according to the law of the state to which the employee's service and wages are assigned. Employees in Puerto Rico and in the Virgin Islands are paid in accordance with the law of the District of Columbia. The Secretary is authorized to use the personnel of public employment offices in Puerto Rico and the Virgin Islands for processing claims and paying benefits in those possessions. Claimants denied benefits are entitled to a fair hearing held in accordance with regulations prescribed by the Secretary, and any final determinations made in accordance with those regulations are subject to the same court review available to claimants under the Federal Old-Age and Survivors Insurance Act.

Separated employees on annual leave with pay are not considered to be unemployed until their accrued leave has been exhausted.

Benefits first became payable beginning with 1955. But service and compensation are assigned beginning as of 1953. Thus it was made possible for a substantial "backlog" of employees separated before they could otherwise have qualified under state laws to draw benefits beginning as early as January, 1955.

VETERANS' BENEFITS

Congress enacted the Servicemen's Readjustment Act of 1944. That Act, among other things, provided money allowances for released servicemen while they were finding employment, the money to be paid out of Federal funds. For total unemployment, \$20 per week was allowed, and for partial unemployment \$20 per week less wages earned plus \$3, rounded out to the next highest dollar when the computed amount did not end in a multiple of \$1.

To be eligible, one must have had active service in World War II for a minimum of 90 days, unless released before that because of injury incurred in service in line of duty. Release must have been under conditions other than dishonorable. One must have been residing in the United States at the time application for benefit was made, unemployed, registered for work with a public employment agency, available and able to work unless prevented by an illness or

disability which occurred after the commencement of a period of continuous unemployment.

For the first 90 days of active service, the amount of benefit allowed was eight weeks for each month of service; for service beyond 90 days, four weeks of benefits were allowed for each month or major fraction thereof. A maximum of 52 weeks of benefits was allowed, payable within two years after discharge or the end of the war, whichever was later. And there was an overall time limitation for benefits of five years after the termination of hostilities.

The benefits were not payable for any period of time in which a serviceman was receiving vocational rehabilitation or educational subsistence allowances. If he was receiving unemployment or disability compensation under a Federal or state law, or retired pay from the Veterans Administration, those amounts were deducted from his readjustment allowances under this act.

Servicemen could be disqualified for benefits under certain conditions, as follows: (1) for voluntarily quitting a job without good cause; (2) failure without good cause to apply for suitable employment to which one had been referred by public employment agencies, or to accept suitable employment if offered; (3) discharge or suspension for misconduct in the course of employment; (4) failure without good cause to attend an available free training course if required by regulations; (5) unemployment due to a stoppage of work resulting from a labor dispute. Suitable employment and good cause were to be determined according to the standards of the state through which the servicemen got their benefits.

The plan was administered by the states, and the Federal government reimbursed them for sums paid out in benefits and for all expenses of administration as well. It was terminated in July 1947. A new plan, similarly administered but not wholly financed by the Federal government, was established after the Korean incident began; it was applicable to those serving after June 26, 1950, until a termination date to be established by Presidential proclamation or Congressional action.

Servicemen are entitled to \$26 weekly for a maximum of 26 weeks. Any veteran entitled to a state benefit of \$26 or more receives that benefit from the state; if entitled to less than \$26, his benefit will be increased to \$26. The Federal government pays all the benefits of those not eligible under a state law, and pays the difference between

what the state may be obligated to pay and the \$26 guaranteed by the law.

MARITIME BENEFITS

Maritime workers were excluded from coverage when the Social Security Act was passed, although an unsuccessful attempt was made at that time to establish a separate and nationally administered system for maritime and railroad employees.¹³ Most state laws excluded maritime workers. One reason for this action was the difficulty of administration involved in state coverage, and another was the belief that states could not constitutionally tax maritime employers. However, New York asserted jurisdiction over maritime workers in the state and was challenged in two cases reaching the United States Supreme Court.¹⁴

The Supreme Court held that Congress had specifically permitted states to levy taxes which affect interstate commerce, that no "essential feature of an exclusive federal jurisdiction" was involved in state unemployment compensation laws, that nothing in the legislative history of the Social Security Act indicates a Congressional intention to forbid states to cover maritime employment, and that some state acts include other employments not subject to the Federal tax.

Most states with maritime workers then proceeded to extend the coverage of their acts to such workers. However, some did not, and that created a competitive problem. Because much maritime employment is itinerant and begins in various ports of the U.S. and sometimes even in foreign countries, state coverage necessitated reciprocal agreements. Furthermore, most maritime workers were employed on vessels operated under a War Shipping Administration general-agency agreement and were considered to be Federal employees and therefore not under state jurisdiction.

Two steps were taken by Congress in 1946 to remedy the situation. Both steps met with the approval of maritime unions and employers and of state unemployment compensation agencies as well.

The Federal Unemployment Tax was levied on private maritime

¹³ *Issues in Social Security*, 79th Cong., 1st Sess., pp. 399-409; *Hearings Before the House Committee on Ways and Means on Social Security Legislation*, vol. 3 (indexed).

¹⁴ *Standard Dredging Co. v. Murphy*, including *International Elevating Co. v. Murphy*, 319 U.S. 306, decided May 24, 1943.

employment. States in which persons or companies maintain offices supervising, managing, directing, or controlling the operation of American vessels operating on navigable waters within or without the United States may now include those persons or companies within the coverage of their unemployment compensation laws. All of the employees of those persons and companies then become subject to the unemployment compensation law of the state in which the "home" or controlling office is located, no matter where their maritime duties may take the workers, and they are not subject to the unemployment compensation law of any other state. One condition is imposed. All of the service performed for the company or person which is covered by the state unemployment compensation act must be treated the same in regard to employee wage credits and taxes on employers and employees, if taxes are levied on employees. However, no existing and effective provision in any state unemployment compensation act that conflicts with this act was to become invalid until January 1, 1948.

The second action relates to individuals employed in Federal maritime service, over which states have no jurisdiction. It provides "reconversion unemployment benefits" for such workers. The reconversion period as defined in the amendment begins with the fifth Sunday after the date of enactment, which would be September 8, 1946, and ends June 30, 1949. The Congress did not appropriate money to meet the cost of this program in the session in which it enacted the law, and the payment of benefits therefore had to be postponed until the necessary appropriations became available. Appropriations have been made, and benefits became payable for unemployment on and after July 8, 1947.

The Federal government, through the Secretary of Labor, has made agreements with the states under which the states act as its agent in paying unemployment compensation benefits to eligible Federal maritime workers and coöperate with the Federal government and other states in making such payments. Compensation benefits are in general "in the same amounts, on the same terms, and subject to the same conditions" that would obtain if the service were included under the state law. Thus any discrimination as between Federal and private maritime workers is prevented. The Federal government reimburses the states for benefits paid, or advances the amounts needed for benefits if that is necessary. It also pays the cost of administering the plan.

Should there be any state having Federal maritime workers with which no agreement is concluded, or should a state having an agreement fail to make payments in accordance with that agreement, then the Secretary of Labor will make the payments that would have been payable under the state law had there been an agreement, or had an existing agreement been observed.

In cases where it is not feasible for Federal agencies or operators to furnish the information necessary to permit reasonably prompt determinations of wages and salaries earned, the average weekly wage or salary in the last pay period may be used as if it were the actual wage or salary for the entire period. If even that information is not available, facts as to service and wages as certified under oath by the individual concerned will be accepted. Appropriate penalties are provided for fraudulent statements or representations or failure to provide information.

CHAPTER ELEVEN

STATE UNEMPLOYMENT COMPENSATION ACTS: PROVISIONS

BY LEVYING a 3 percent tax on pay rolls and providing for tax offsets and additional credits, the Federal government has in effect compelled the states to enact unemployment compensation legislation. But it has left them considerable freedom in the matter of the kind of law to be enacted. As a result, state acts differ appreciably from one another, although there is some degree of uniformity. The following description of the major provisions of state acts is therefore necessarily in very general terms.

COVERAGE

The Federal act, it will be recalled, is restricted as to employments and employers covered. The pattern established by that act was largely followed by the states. But there has been a strong tendency for the states to go beyond the Federal limitations.

Employments. State acts for the most part include only the employments covered by the Federal tax, or to put it in other words they generally make the same exclusions. There are numerous exceptions in which states have gone beyond the Federal employment exclusions. Idaho, for example, includes domestic workers, and Hawaii and Tennessee include those of nonprofit scientific, literary, and of certain charitable organizations. New York includes domestic workers in private homes if four or more are employed. State employees, employed students, and casual workers are included in a substantial number of states. Service for foreign governments is included in some acts. In 1945, California authorized voluntary coverage of self-employed persons.

Numerical Limitations. Numerical limitations vary quite considerably as between states, and it is significant that more than half of the acts apply to employers of fewer employees than does the Federal tax. Approximately 45 percent apply only to employers of eight or more, as in the Federal act. An increasing number, now over one-third of the total, apply to employers of one or more. The others specify some number between one and eight, most commonly four. Some states have alternative provisions. Kansas extends coverage to employers of eight or more in 20 weeks or 25 or more in any one week. Minnesota's law covers employers of one or more in 20 weeks in cities of 10,000 or more, but outside of such cities only eight or more. It is estimated that numerical limitations exclude altogether about 3.3 million workers. A total of 29 states have a provision in their laws that will automatically extend coverage to make it coincide with the scope of the Federal act, should that act be made more liberal than the state law.

Earnings. Several states prescribe coverage in terms of amounts earned, but there is little uniformity among those provisions. Idaho, for example, provides that coverage shall extend to all employers with pay rolls of \$75 or more in one quarter, while Nevada specifies \$225 or more in one quarter. A number of states use both numerical and wage criteria. Kentucky specifies four in 20 weeks or wages of at least \$50 to each of four workers during each of three quarters, and Nebraska specifies eight or more workers in 20 weeks or a \$10,000 quarterly pay roll.

Weeks of Employment. Most of the laws follow the Federal act's coverage in specifying employment "on any day within each of 20 weeks," each day being in a different calendar week. But many of them use the formula "within each of 20 weeks." The latter is somewhat more inclusive, because it merely requires that the specified number of different workers, say eight, have been employed during the week, whereas under the former they must have been employed during the same day. In an increasing number of states, the tax is on any wages earned by any worker at any time in a covered employment, but not on amounts in excess of \$3000 per year for any one worker. And in all states, if an employer falls within the specified limits his pay roll for the entire year is taxed.

Voluntary Coverage. There are some employers with workers in more than one state who are subject to the Federal tax but not to

the taxes of one or more states. Also there may be some not subject to either Federal or state taxes who would like to see their workers enjoy the protection of unemployment compensation. All states permit such employers voluntarily to elect to come under the state laws. There is also an interstate agreement, not universally participated in, which makes it possible for an employer with workers in several states to come under the law of only one state.

TYPES OF FUND

One basic distinction between acts lies in the manner in which the tax money is raised, accounted for, and used. There are now two types of fund: the pooled fund with experience rating, and the employer's reserve with a supplemental pool.

Pooled Fund with Experience Rating. The most common type is the pooled fund with experience, or merit, rating. Here all employers contribute to the same general fund, from which unemployed workers draw benefits without regard to the amount of their employers' contributions. But employers do not contribute at the same rate. In this type of plan, benefits paid to an employer's workers are charged against him for accounting purposes, and sometimes where more than one employer has incurred liability some are charged back to previous employers in inverse chronological order. The rate of tax paid by the employer depends upon his unemployment experience.¹ Different types of experience-rating plans will be described below.

Employer Reserve with Partial Pool. The second type is a combination of individual employer reserves and a state-wide com-

¹ At one time there were states which had pure pooled funds. All employers paid the same tax rate, irrespective of the amount of unemployment among their employees. The money was all put into one state fund and no part of it was thereafter subject to the control of the individual employer paying it. Benefits were paid from this fund to unemployed workers of covered employers, irrespective of the amounts collected in taxes from the employers of those unemployed workers. No record needed to be kept of the amount of benefits paid to the unemployed workers of any given employer, for the tax rate paid by that employer bore no relation to those benefits. It was necessary to keep a record of the benefits paid to workers, however, for those benefits were limited in time or amount or both. The type was abandoned for the simple reason that the Social Security Act made no provision for uniform rate reductions. It exists in the Railroad Unemployment Insurance system, where uniform rate reductions are possible.

mon pool. At the end of 1953, Kentucky was the only state with this type of fund. At one time there were many more. In this type, each employer has a separate account to which a part of his tax contribution is credited. The remainder of his contribution and all interest on money in the Unemployment Trust Fund as well as interest and penalties collected from employers are put into the state-wide pool. Benefits paid to unemployed workers are charged to their employer's reserve account, and it can be said that they are paid from that account. Should the employer's account be exhausted, then workers still eligible for benefits would draw them from the central pool. The amount of taxes paid by employers is directly related to the amount of benefits paid to their workers. Provision is made for replenishing the central pool by raising tax rates and increasing the amount going to the central pool.²

BENEFITS

Unemployment compensation provides cash benefits for only brief periods of time. The problems involved in providing those limited cash payments are many and difficult. In framing their systems, American states did not follow any other well-established system. Draft bills embodying numerous alternatives and prepared by the Social Security Board were used as guides in most states. We are still in the experimental period of unemployment compensation. Every legislative session results in many changes and it is therefore impossible at this time to give a stable account of the major benefit provisions of American acts. The following description should, however, be helpful.

The amount of compensation an unemployed worker will get depends upon the waiting period, the duration or maximum amount of benefits, and the weekly benefit rate.

Waiting Period. Only Maryland and Nevada have no waiting period, i.e., specified numbers of days or weeks of unemployment be-

² At one time Wisconsin had what may be called a pure employers' reserve type of law. Under it employers' contributions were credited to their individual accounts, known as "reserve accounts," and benefits were to be paid to unemployed workers out of their employer's reserve account. Each employer was liable only for the unemployment of his own workers, and every worker depended altogether on his employer's reserve account for his benefits. Later a partially pooled fund was introduced, and in 1945 the employer-reserve system was abandoned.

fore benefits become payable. These waiting periods are intended to prevent heavy drains on funds while unemployed workers presumably still have some resources, to hold down administrative costs by reducing the amount of detailed work involved in many small claims, and to give administrators time before benefits are paid in which to determine whether claimants are eligible, and if so to compute the amount and duration of their benefits.

Nearly all of the laws require only one week of waiting in the benefit year, although a few still require a maximum total of two. New York's requirement is four "effective" days in the benefit year. An effective day is the fourth and each subsequent day of total unemployment in a week beginning on Monday in which the claimant earns not more than \$30. A full week of unemployment results in four effective days. An increasingly large majority of the acts count a week of partial unemployment the same as one of total unemployment in meeting the waiting-period requirement. A few still count two partial weeks as equal to one full week. Benefits are generally not retroactive if unemployment lasts beyond a specified time, as is frequently true of workmen's compensation benefits. In nearly every state, each benefit year has its own waiting period which cannot be met with unemployment occurring in the preceding year. Once the initial waiting-period requirement has been satisfied, either there is no subsequent waiting period in the same benefit year, or there is a shorter one. A few states provide that the waiting period may be increased if the solvency of the fund is in jeopardy.

Weekly Benefit Rates. The weekly benefit rate is generally based on the amount of wages earned, and the maximum is designed to approximate one-half of the amount that would be earned by a person employed full-time at low wages. Wages earned in covered employment are normally credited to the worker's account quarterly. Reports are usually made by employers within 30 days after a quarter has ended, although some states require only semi-annual or annual reporting. The "base period" used in computing the benefit amount and duration in 60 percent of the states consists of the first four of the last five completed calendar quarters immediately preceding a worker's benefit year. This is known as the "individual" base period. In approximately one-third of the states the base period is uniform for all workers, and it may be the calendar year or some other 12-month period, a device which is administra-

tively simpler. There are various other plans, but at the end of 1953 no state had a base period of more than four quarters.

No two states use exactly the same method for determining the weekly benefit rate. For total unemployment, the rate is most commonly determined by selecting that quarter of the base period in which wages were the highest and taking a fraction, most commonly 1/20th. In 1948, approximately 80 percent of the states used the high-quarter basis. If for example the highest quarterly earnings are \$400, then 1/20th of that would be \$20, which would be the amount of benefit paid weekly.

A few states have "step-down" plans. A worker whose high-quarter earnings would yield him a weekly rate of say \$20 might not be eligible for benefits because his base-period earnings did not equal a required amount, say 30 times the weekly benefit amount, which would be \$600. But under a plan of this type he would be permitted to qualify at a rate which multiplied by 30 would equal his base-year earnings. If those earnings were \$580, his rate could be set at \$19. It is common to "round out" the weekly benefit amount to the next highest dollar.

Maximum weekly benefit amounts are specified in all laws. The most common maximum specified is \$26, the next \$20, and the next \$24. A substantial number of states increased their maximum weekly rates to bring their laws into harmony with the Federal Servicemen's Readjustment Act of 1944, which provides a flat unemployment benefit of \$20 weekly. The high wage levels achieved during the war and postwar years call for further adjustments in maximum weekly benefit rates. By the end of 1953, nearly 90 percent of the states, with more than 90 percent of all covered workers, had a maximum of \$20 or more, and only four had a maximum of \$16.

As of January 1, 1949, only six laws provided additional benefits for dependents. By the end of 1953 there were 11. Ten of these specified dollar amounts; Alaska provided 20 percent of the weekly benefit amount. Dollar amounts specified were one, two, and three, each in three states, and one specified \$2.50. Usually the same amount is payable for each dependent, but in a few laws additional dependents are allowed different amounts.

Every state sets a limit on the total amount of benefits payable to dependents. In most cases there is a flat dollar maximum varying from \$3 to \$12. Some states put the limit at a percentage of average weekly or high-quarter wages, as 100 percent of average weekly

wages, 6 or 8 percent of high-quarter wages. In one state the limit is 60 percent of the weekly benefit amount and in another it is 50. The District of Columbia sets the limit for combined benefits at the absolute maximum established for unemployed recipients. The net effect is that only in Massachusetts can any claimant receive allowances for more than four dependents. For claimants receiving the maximum weekly benefit amount, the total of dependents' benefits ranges from zero to \$18.

In every state children under ages ranging from 16 to 19, most commonly under 18, are considered dependents, although in some states older children unable to work are likewise included. Four states include wife, husband, one parent, and brother or sister, if dependent upon the claimant.

There is a great deal of partial unemployment in practically all industries and occupations. Acts are designed to compensate underemployment as well as total unemployment. Practically all states provide benefits for partial unemployment, which is usually considered to exist when a worker's weekly earnings are less, because he lacks work, than the amount his unemployment benefit would be if he were totally unemployed. The amount of weekly partial unemployment benefit is usually the difference between the total unemployment benefit amount and the amount earned, disregarding small sums of from \$2 to \$3 earned during periods of partial unemployment. Small sums so earned during total unemployment are also usually disregarded.

Partial benefits thus help the worker with short employment, of which there are a great many, especially in steel, textiles, coal mining, clothing, and lumber. They also eliminate the possibility that a worker might receive less money if he works part time than if he is totally unemployed. Partial benefits also make it more difficult for employers to control, by spreading work, the amount of benefits paid out in order to secure a more favorable experience rating, and for other employers to subsidize wages by alternating full employment with total unemployment. The administration of partial unemployment benefits is perhaps the most difficult single problem in the system.

All states provide for minimum as well as maximum benefits. In January of 1954 only one state had a minimum of less than \$5 for total unemployment. The most common figure was \$10, found in approximately 31 percent of the states, and the next most common was \$5, found in 23 percent of the states. The highest minimum was

\$15. Dependents' allowances, where they exist, are added to the statutory minimum. Approximately 55 percent of covered workers are in states with \$10 minima and less than one-eighth in states paying less than \$6. The total amount which can be drawn in any benefit year by one who qualifies for only minimum benefit rates ranges from \$260 in one state down to less than \$30 in four states. Some 13 percent of covered workers are in states where potential minimum annual benefit payments amount to \$50 or less.

Duration of Benefits. The number of weeks for which benefits may be paid is important to the worker because of the effect on his standard of living, and to the administration of an act because of its effect on the solvency of the fund. The employer is also interested because of the effect on his taxes; and the community is interested because of the possibility of having to provide general or work relief after benefits are exhausted.

Benefits are limited in terms of time or total amount or both during any one benefit year. In most states, 73 percent, each worker has his individual benefit year, which is usually defined as the 52-week period beginning with the week or day on which he files a valid application for benefits. The remainder have uniform benefit years, most commonly the calendar year, and the trend has definitely been toward uniform benefit years. The beginning dates where uniform benefit years are used were selected according to whether the state wanted to make benefits most available when most needed, i.e., during the period of greatest unemployment, or whether it wanted to flatten out the peak benefit load and thus simplify administration, i.e., to begin the year with the period of fullest employment, or to allow a certain lag after a calendar-year base period irrespective of the relationship to unemployment. Most states chose the last method, some allowing a lag of one quarter, others more.

Uniform base and benefit years permit the use of annual or semi-annual reports if an annual wage benefit formula is used. But they do result in a concentration of claim loads at the beginning of the benefit year, or just before that year begins.

The most common type of provision limiting duration is that total benefits shall not exceed a specified number times the weekly benefit amount, usually from 20 to 26, and not exceed a maximum amount which is commonly expressed as a fraction, usually one-fourth, one-third, or one-half of base-period wages. In some cases duration is based on a statutory table of base-period earnings. In 1954, approximately 90 percent of the laws had maximum durations of 20 weeks

or more, and about 45 percent paid for a maximum of 26 weeks. Over 67 percent of the covered population in 1954 was in states having a duration of 26 weeks. It is interesting to note that in 1937 only six states, having 12 percent of the covered population, had benefit durations in excess of 16 weeks.

The commonly used formula of a specified number times the weekly benefit amount but not to exceed a given fraction of base-period earning results in such a large proportion of recipients becoming eligible for the maximum duration that by 1948 nearly 30 percent of the states had uniform duration of benefits, and they included about 26 percent of all covered workers. In 1937 there was only one. All workers who qualify receive benefits at their respective rates, which are not uniform, for as long as they are out of work or for the maximum period stated in the law, usually either 20 or 26 weeks. The trend in legislation toward uniform duration of benefits will no doubt continue. Other things being equal, the maximum number of weekly benefits will be less where uniform duration exists than where previous earnings or employment are the controlling factors, but a larger proportion of the workers would get more benefits. Seasonal workers whose benefits are not especially limited by law or administrative order profit most from uniform duration. Duration of benefits in a few states depends upon the amount of employment during the year, or on earnings in the different quarters.

Eligibility for Benefits. In order to be eligible for benefits, a person must be in covered employment, out of work, able and willing to work, and unable to find a job. In a substantial number of states he must have made efforts to secure employment. Furthermore, he must have fulfilled the waiting-period requirements. He must also have earned enough in covered employment to show that he is normally attached to that market and is not just a "Saturday-afternoon-clerk" type of worker.

One method used by approximately 45 percent of the states to achieve this end is to require that during his base period, which is one year in practically all states, a worker shall have earned wages at least equal in amount to a specified number times his weekly benefit amount, say 20 or 30 times. If the benefit is 50 percent of wages and the eligibility requirement 30 times the rate, then the worker must have had some employment in at least 15 weeks. Those with high earnings qualify in fewer weeks than others. In a few of these states, earnings of from 20 to 30 times the weekly benefit

amount are required, but it is specifically provided that there be earnings in more than one quarter of the base period.

Another method, used by about 35 percent of the states, is to require that a specified sum of money, ranging from \$100 to \$600, has been earned during the base period, and a few states require in addition that there be some earnings in more than one quarter. There has been something of a shift from the multiple-benefit method to this one. The effect is a tendency to exclude persons who have employment during only one quarter, and also to exclude relatively more women, because of their low wages, than men. All low-paid workers are at a relative disadvantage in this plan if their employment is erratic, more so than in the multiple-benefit method. However, this method is the simplest to administer and the easiest to understand.

Disqualifications. There are certain conditions that disqualify altogether or for a limited period of time a person who would otherwise be eligible for benefits. The disqualification may consist of postponing the payment of benefits for a specified period of time without affecting the total number of weekly benefits the disqualified worker may draw, cancellation of wage credits or benefit rights in addition to postponement, or it may reduce the total number by the amount of the penalty. The trend has been towards the latter type of provision. In 1947, for three major disqualifications, namely quitting a job without good cause, refusal to accept suitable work, and misconduct, 27 states only postponed benefits and 24 provided for cancellation of wage credits or benefit rights in addition to postponement. In one-third of these latter, reductions were mandatory, in all other states application of the penalty was left to the discretion of the administrative agency.

Any one who quits his job without good cause or who is discharged for misconduct connected with his work may be penalized by being deprived of benefits altogether or for a limited period of time. In some states, "good cause" for quitting is limited to causes "attributable to the employer," a provision which is reminiscent of the common-law doctrines of contributory negligence and assumption of risk which were discarded by workmen's compensation acts. Some states accept personal reasons, such as health, unavailability of good transportation, and burdens of motherhood.

One who has failed without good cause to apply for or accept suitable employment may in most states also be similarly penalized.

One state went so far as to deny benefits to workers who refused to accept jobs in any of their prewar occupations at prevailing rates, even though they had acquired new skills paying appreciably higher wages. The tendency during the war and postwar years was to increase the severity of this disqualification.

Workers on strike or locked out are generally disqualified from receiving benefits, usually irrespective of the merits of the dispute, although a few states do not disqualify workers locked out. Some laws do not disqualify if the strike is over the employer's violation of a state or Federal law. In 1953 the strike disqualification in two states was for only a specified number of weeks, and after that period has elapsed strikers may draw benefits.

Strikers are disqualified for benefits because it would be unfair to subsidize them and to impair the neutrality of the compensation agency. Workers in an establishment who are not themselves on strike, but who are unemployed because of a strike of others in the establishment, and who are helping to finance it or who are directly interested in the outcome, and who are of the same grade or class as those on strike, are sometimes disqualified. The reason for this is that such workers are directly interested in the strike because the terms and conditions of their employment are the same as those of the persons on strike and they stand to gain if the strike succeeds. In some states refusal to cross a picket line is deemed to be participating in a strike unless the refusal is based on justifiable fear of bodily injury.

For women, more than one-half of the states have some special disqualifications. In some of these states a woman will be disqualified for benefits if she quits work on account of marital obligations, in others if she becomes pregnant, and sometimes both constitute disqualifications. In some states a pregnant woman is considered to be either not available for work, or unable to work, or not seeking work and therefore disqualified.

Any worker who receives a dismissal wage or workmen's compensation payments is, for the weeks in which he receives those payments, disqualified from receiving unemployment compensation. He is also disqualified if he is receiving Federal Old-Age and Survivors Insurance benefits, or unemployment compensation benefits from any other public system, equal to or greater than his unemployment benefit, but if they are lower than his unemployment benefit they are deducted from that benefit.

Seasonal unemployment presents one of the most difficult problems in our unemployment compensation system. The danger involved is that workers in seasonal industries, who are generally certain to be unemployed a period of time nearly as long or longer than the maximum duration of benefits, will receive the maximum amount of benefits yearly and thus cause a heavy drain on the benefit funds, at the expense of other workers. There are some who believe that benefits paid to seasonal workers in effect amount to a wage subsidy to such workers or to their employers.

Somewhat more than half of the acts have special provisions relating to seasonal employments, provisions designed to restrict the seasonal worker's rights to benefits. Two general types of restrictions are found. In one type, the benefits of workers of any group or class of employers who regularly operate less than the entire year are restricted to receiving benefits during the longest customary seasonal period or periods of operation, but benefits are to amount to a "reasonable proportion" of the employers' contributions. Compensation agencies are permitted to classify as seasonal any industry which lays off say as many as one-third of its employees for six months or more. The second type of restriction defines as seasonal any industry which operates for a customary period of less than a specified number of weeks, usually 40.

Although the necessity for seasonal restrictions is apparent, the difficulty of administering any seasonal restriction is great. It is difficult to define what industries are seasonal enough to be subject to restrictions, the length of the seasons, and the times of beginning and ending, and where an industry has both seasonal and non-seasonal workers, which are the seasonal workers. As a result, legislative provisions regarding benefits for seasonal workers are frequently ignored. Indirect approaches to the problem are to require earnings in two of three quarters or to gear duration of benefits to earnings by quarters.

EXPERIENCE RATING

All state laws now provide for experience rating. There are at least five distinct types of formulas for determining rates of contributions, and for most of the types there are numerous variants. Each of them is devised to relate the individual employer's taxes to benefits paid to his workers, directly or indirectly, each sets up

standards for measuring unemployment, and each establishes a measure of exposure to relate employers' experience.

The Reserve-Ratio Formula. The reserve-ratio formula, used in 60 percent of the states having approximately 70 percent of all workers in covered employment, is a simple cost-accounting plan designed to collect from each employer enough money to cover the benefits paid to his unemployed workers plus a small reserve.

Each employer's experience-rating account is credited with the contributions he has made and is charged with the benefits paid to his unemployed workers. Total cumulative contributions credited minus total cumulative benefits charged equals the employer's reserve. The reserve is then divided by the taxable pay roll to get the reserve ratio. Most states use the average taxable pay roll for the preceding three years.

Suppose for example that an employer's cumulative taxes total \$75,000, his cumulative benefits total \$35,000, and his average annual pay roll is \$400,000. His reserve would be \$40,000, which divided by his pay roll would make his reserve ratio 10 percent. His tax rate would then be determined according to a legally prescribed schedule of rates for various reserve ratios. There is considerable difference among the various state schedules, and the following is given as an example. If the reserve is:

Less than 4%, the tax rate is	2.7%
Between 4% and 6%, the tax rate is	2.2
Between 6% and 8%, the tax rate is	1.7
Between 8% and 10%, the tax rate is	1.2
10% or more, the tax rate is	0.7

The employer in the above example would pay a rate of 0.7 percent of his covered pay roll.

But in order to protect its fund against depletion, a state law might provide that irrespective of his reserve ratio, no employer's tax rate may be lower than 2.7 percent unless the total assets in the state's unemployment account exceed the total benefits paid out in the preceding year; and no employer's rate may be less than 1.7 percent unless total assets are at least twice the total benefits paid in the preceding year.

Rates under this formula are geared to long-term experience, since contributions and benefits are cumulative over the employer's entire experience, and pay rolls are usually averaged over the preceding

three years. Furthermore, increasing pay rolls tend to increase tax rates, and vice versa, unless the employer is already paying the maximum rate. This tends to build up the reserve during prosperous years.

Benefit-Ratio Formula. A second simple method used is the benefit-ratio formula, used in six states in 1948, having 10 percent of all workers in covered employment. In this method, the employer's total benefits for a specified period of time, usually three years, are divided by his total pay roll for the same period to derive his "benefit ratio." The tax rate paid by the employer is then determined by comparing his benefit ratio with a schedule set up in the law. The schedules vary considerably as between laws, and the following is given as an example. When the benefit-ratio is:

Less than 1.0%,	the tax rate is 1.0%
1.0% or more but less than 1.3%,	the tax rate is 1.3
1.3% or more but less than 1.6%,	the tax rate is 1.6
1.6% or more but less than 1.9%,	the tax rate is 1.9
1.9% or more but less than 2.2%,	the tax rate is 2.2
2.2% or more but less than 2.5%,	the tax rate is 2.5
2.5% or more but less than 2.8%,	the tax rate is 2.8
2.8% or more but less than 3.1%,	the tax rate is 3.1
3.1% or more but less than 3.4%,	the tax rate is 3.4
3.4% or more but less than 3.7%,	the tax rate is 3.7
3.7% or more,	the tax rate is 4.0

Suppose for example that an employer's total pay roll for three years is \$300,000 and his benefits for those years total \$6000. His benefit ratio would be 6000 divided by 300,000, or 2.0 percent. His tax rate would be 2.2 percent.

This formula is generally geared to short-term experience, since the time period is usually limited to the three preceding years. Increasing pay rolls tend under this method to reduce rates, and vice versa. Thus when business is expanding, and when employers presumably are better able to pay, taxes may be lowered.

Benefit-Wage-Ratio Formula. A third method, differing radically from the first two, is known as the "Benefit-Wage-Ratio" formula. In 1954 it was used in six states having about 10 percent of all workers in covered employment. In this method, the total amount of compensable unemployment experienced by any given employer's workers is measured indirectly as a part of the state's total unemployment, and not directly as in the two preceding methods.

One step in the method is to compute the employer's benefit-wage ratio, sometimes called his experience factor. Benefit wages are the taxable wages earned in their base periods by those of his employees who have been separated and have drawn benefits. In some laws maximum amounts of creditable wages are specified, as \$1200 per year for example. The first time a worker receives benefits in his benefit year, his base-period wages become benefit wages, and they are considered as having been paid in the calendar year in which the benefit is paid. If the worker is rehired and again separated and paid more benefits in the same benefit year, no employer's experience factor is further affected, since his entire taxable base-period wages become benefit wages only once in any given year. If in his base period a worker received pay from several employers, each employer is charged with the amount of wages he paid that worker in his base period.

Next, the employer's benefit wages for all of his separated and compensated workers are totaled, for the most recent three consecutive years. This total is then divided by the employer's total taxable pay roll for those years. The result is his benefit-wage-ratio, or experience factor.

An example will be helpful. The base period will be considered as the first four of the five completed calendar quarters immediately preceding the first day of a benefit year. The benefit year consists of the 52-week period beginning with the filing of a valid claim which results in the payment of benefits. Both could, of course, be uniform for all, i.e., fixed calendar periods, or both may be individual as here assumed.

In determining an employer's benefit-wage-ratio for the purpose of assigning him rates in 1950, the taxable wages earned in 1948 by his workers whose benefit years began in 1949 are considered as having been earned in 1949. Similarly, benefit wages earned in 1947 and 1946 are considered as having been earned in 1948 and 1947 respectively. Suppose those benefit wages total \$25,000 and total taxable wages for the same years amounted to \$125,000. Then \$25,000 divided by \$125,000 equals 20 percent, and this is the employer's benefit-wage-ratio or experience factor.

Next the state experience factor is determined. This is done as follows. First the total amount of benefits paid from the state fund for the three preceding years is ascertained. Assume that was \$2.5 million. From this sum are deducted any penalties or interest paid

by employers on account of overdue payments or for other reasons, and also all interest earned by the reserve fund. Assume these deductions to be \$0.5 million. Then \$25 million minus \$0.5 million leaves \$24.5 million. This is the "amount required from employers" to replace the amount paid out in benefits. The amount required from employers is then divided by the total amount of benefit wages for the state for the same three years, and amounts to the sum of individual employers' benefit wages. Assume the amount to be \$20 million. Then 24.5 divided by 20 equals 122.5 percent, which is the State Experience Factor and means that 122.5 cents per dollar on the amount of benefit wages paid is needed to replenish the fund.

The employer's tax rate is then determined by reference to a statutory table which shows what that rate is to be, given the state experience factor and the employer's benefit-wage-ratio. In our example, the rate would be 2 percent on taxable wages.

Variations in rates as between states using this method are not great. If the state experience factor is 10 percent and the employer's benefit-wage-ratio 20 percent, the tax rate will be 2 percent in nearly all states. There are differences in maximum and minimum rates, and also in the reference tables. Increasing pay rolls tend in this method to reduce rates. The method embodies the "pay-as-you-go" principle, as does the Connecticut plan described below.

Compensable-Separations Formula. A fourth method is known as the compensable-separations formula, and is used only in Connecticut. As in the benefit-wage formula, number of compensable separations is used as a measure of unemployment, and each employer is charged with only one separation for each period of continuous unemployment.

One step in this plan is to compute the employer's Merit-Rating Index, which is done yearly as of December 31. An employer's Merit-Rating Index is derived by dividing his Experience Pay Roll by the Rated Amount of Compensable Separations. The Experience Pay Roll consists of the aggregate amount of taxable wages payable for employment during the three preceding years.

Rated Amount of Compensable Separations may be explained as follows. At the beginning of the first compensable period of unemployment in a worker's benefit year, the amount of his weekly total benefit payment is charged to the account of every employer who in the preceding 56 days (8 weeks) employed that worker during at least four different calendar weeks. Any subsequent benefits paid

to that worker in his benefit year have no effect and no further charges are made on account of benefits paid to him.

Let us suppose that an employer's taxable pay roll for the three preceding years amounts to \$300,000, and that his rated amount of compensable separations for the same three years is \$50,000. His Merit-Rating Index is then 300,000 divided by 50,000, or 6.

Next the taxable pay rolls for the three preceding years of all employers with merit-rating indexes are totaled. This total is then divided into 13 approximately equal parts. These parts are then arrayed so that the first part shall consist of the pay rolls of employers with the lowest merit-rating indexes, the 13th part of those with the highest, and the others in accordance with this order.

Suppose the aggregate pay rolls amount to \$1.3 billion. Then each part would consist of approximately \$100 million. If in order to get an exactly equal division it would be necessary to split an employer's pay roll into two parts, his entire pay roll would be included in the lower numbered of such two parts. We could then have something like the accompanying, abbreviated array.

Part	Pay Roll (In Millions)	Merit Rating Indexes
First	\$100.0	Less than 2.0
Second	100.2	2.0 to 2.99
Third	99.9	3.0 to 3.99
Fourth	99.9	4.0 to 4.99
Thirteenth	100.0	13.0 and above

The rate of tax to be levied would then be determined for each employer by comparing the part in which his merit-rating index appears with a table in the Act which specifies the rates applicable to each employer in each part. There are five schedules and the one used will depend upon the reserve. If, for example, the balance in the unemployment compensation trust fund is equal to at least 2 percent of the taxable pay roll in the three-year experience period, the rates vary from 2.7 percent for those in the first part to 1.5 percent for those in the 13th part. If the balance in the unemployment trust fund is at least 1.25 percent but less than 2 percent, the rates vary from 2.7 for the first part to 2.1 for the 13th. Any employer entitled to experience rating who in the three-year experience period has had no compensable separations charged to his account and who has made all required contributions is entitled to the rate

charged for the 13th part. If the balance in the fund is less than 1.25 percent, all pay 2.7 percent.

In 1947, Connecticut provided for distributing "surplus" contributions to those experience-rated employers whose rates are not set at 2.7 percent. A surplus exists when the balance in the state's account in the Federal Unemployment Trust Fund exceeds 4.5 percent of the preceding three years' taxable pay roll and when the current year's contributions plus interest earned during that year by its balance in the Unemployment Trust Fund exceed benefit payments made during that year. The surplus consists of the excess of contributions over benefits. It is distributed to eligible employers in the same proportion that their contributions bear to total contributions of eligible rated employers in the preceding 12 months. The distribution is in the form of credit memoranda, which are valid only for paying unemployment compensation taxes during the current year.

Pay-Roll Variation Plans. It is possible to merit rate individual employers without direct reference to the benefit payments made to their employees or to the amount of contributions they have made. Pay-roll variation plans are used for this purpose. Declines in pay rolls, annual or quarterly or both combined, constitute the measure. Those using this type of plan believe that changes in the general level of business activity and seasonal and irregular operations are reflected in pay rolls, and that declines in pay rolls reflect unemployment and unemployment benefits. This method makes it unnecessary to keep records of the benefits paid to individual employees in order to charge them, directly or indirectly, to the employers concerned.

A pay-roll variation plan using annual declines as a measure may be quite simple. The Mississippi plan is an example. Annual pay rolls for the preceding five fiscal years are listed in chronological order. Assume, for example, the following pay rolls: for the fiscal year ending June 30, 1949, \$120,000; for 1950, \$115,000; for 1951, \$125,000; for 1952, \$130,000, and for 1953, \$120,000.

The decline in 1950 as compared with 1949 is \$5000. This decline is divided by the pay roll for 1949. The resulting percentage figure is 4.166. Expressing the decline as a percentage makes it possible to compare the experiences of large and small employers. In our example there is no decline in 1951 as against 1950 or in 1952 as against 1951, and therefore no computation is made for those years.

For 1953 the decline is \$10,000, which is 7.691 percent of the preceding year's pay roll.

The percentages derived in this way are then added together. The sum is 11.837. In order to get an annual average percentage decline, the sum 11.837 is divided by 4; the result is 2.959. When the individual employer's average annual percentage pay-roll decline has been derived, reference is made to a statutory table which shows what that employer's tax rate will be for the following year. There are several schedules of tax rates in this statutory table, the one used will depend on the condition of the state's balance in the Unemployment Trust Fund, the Federal account in which the state's balance is kept. This condition is expressed as a ratio of the amount credited to the state in the Fund as of November 1 to taxable pay rolls in the state for the preceding calendar year. If, for example, the state's balance were \$50 million and the preceding year's taxable pay roll \$500 million, the reserve ratio would be 10 percent.

In the statutory table employer percentage declines and reserve ratios are grouped into brackets. Thus if the employer's average annual pay-roll decline is between 0 and 6.999 percent, as is true of the employer in our example, and if the reserve ratio is 8 percent or more, as is also true in our example, the employer's tax rate for the following year would be 0.9 percent. Should the reserve ratio be 6 percent but less than 8, the same employer's rate would be 1.5, it would be 1.8 if the reserve ratio were 4 percent but less than 6. The higher an employer's average pay-roll decline, the higher his rate. For those with percentage declines above a maximum of 42 percent, the rate is stated as 2.7 percent, irrespective of the reserve ratio.

There is a further provision to the effect that if the state's balance in the Unemployment Trust Fund is less than \$20 million, no employer shall be given a reduced rate, irrespective of how low his average annual payroll decline may be.

The same procedure may be applied using quarterly pay-roll declines instead of annual declines. In 1954 Rhode Island used the quarterly decline system. Here again the period chosen may be three years or more. It is possible also to combine annual and quarterly declines in one system, and this has been done. The annual and quarterly declines can be added and then reduced to an overall average percentage figure for use in deriving the tax rate. Since quarterly declines especially reflect seasonal and irregular opera-

tions that generally result in the payment of unemployment compensation benefits, some states wishing to stress these factors use quarterly declines as one measure.

A pay-roll variation plan may use the calendar year as well as the fiscal year, and it may use three years instead of five, or more than five. Employers who have not been in the system for the number of years used are not, of course, given reduced rates. The percentage decline figures may be used as a total rather than an average, and a net figure that allows for pay-roll increases may be used. The number of decline or net percentage brackets and the number of tax rate schedules may also be varied within wide limits.

Combinations. Other factors have been combined with pay-roll variations in building a plan. One of these is age, credit toward reduced rates being allowed employers according to the number of years they have been making payments to the system. Another factor is the employer's contribution-benefit ratio, which reflects directly the amount of benefits paid to his workers that are charged to him. The following combinations are suggestive of what can be done.

At one time New York had a complicated experience-rating plan in which rates were based on annual and quarterly pay-roll declines and on the number of years the firm had been covered by the law. That plan has been drastically modified. Basically New York now has an employer-reserve experience-rating plan, but pay-roll variations and age have been retained in it. The employer's account is credited with his contributions and debited with benefits paid to his workers, this is the basic operation in the reserve-ratio plan. The balance in his account is divided by his preceding year's pay roll and the result is called the Employer's Account Factor. This percentage is not applied directly to a statutory rate table as in a simple reserve-ratio plan. Instead, the employer is allowed points based on the size of this Account Factor. If the factor is less than 5 percent, no points are allowed. If it is 5 percent but less than 5.5, he is allowed 1 point. For each additional 0.5 percent he is allowed an additional point until his Account Factor reaches 12.5 percent or more and his points 16. This is the maximum number of points allowed any employer on the basis of his reserve. The number of points allowed is called the Employer's Benefit Factor.

The Employer's Annual Factor is then computed; it is made to depend upon declines in pay rolls during the preceding three years,

in the manner described in pay-roll variation plans. If the sum of these percentage decreases is as much as 0.4 or more, no points are allowed; if it is 0.3 or more but less than 0.4, he is allowed .5 of a point; if 0.2 or more but less than 0.3, he is allowed 1 point; if 0.1 or more but less than 0.2, he is allowed 1.5 points, and if less than 0.1, he is allowed 2 points, which is the maximum. Quarterly decreases are computed similarly and points are allowed depending on the sum of the percentages. The number of points allowed increases from .5 if the sum is 1.5 percent or more but less than 2, to 1 if the sum is 1 percent or more but less than 1.5, to 1.5 if the sum is 0.5 percent or more but less than 1, and to a maximum of 2 points if the sum is less than .5. The number of points allowed is called the Employer's Quarterly Factor.

Credit is then assigned on the basis of the firm's age. If the firm has participated for less than 5 years, .5 of a point is credited; if for 5 but less than 9 years, 1 point is allowed, if for 9 but less than 13 years, 1.5 points are allowed; and if for 13 years or more, 2 points are allowed.

The Employer's Account, Annual, Quarterly, and Age Factors are then added; the sum is his Experience Factor. Reference is then made to a statutory table from which the employer's tax rate is derived. In one column Employers' Experience Factors are arrayed, beginning with all those less than 2 and increasing by one point to the final group, those with 20 or more points. Opposite this list of Employers' Experience Factors are seven different schedules of tax rates; the one that is used depends on the Size of Fund Index, that is, on the condition of the balance in the Unemployment Trust Fund. This index is stated as a percentage and is derived by dividing the balance in the Trust Fund by the pay roll for the preceding year or by an average of the pay rolls for the preceding three years, whichever gives the smaller percentage figure. The first rate schedule is applicable when the Size of Fund Index is 4 percent or more but less than 5 percent; the other schedules are each 1.5 higher than the preceding one, except the last one which is 12.5 or more. When the schedule that is applicable is known, it is a simple matter to find an individual employer's position in the Experience Factor column and the corresponding rate in the tax rate schedule.

Although pay-roll variations are used in New York in computing employer tax rates, its plan obviously is basically a reserve-ratio plan. The maximum number of points that any one employer can

possibly have is 22. As many as 16 of these may be the result of his reserve ratio. Age and pay-roll variations can yield at most 6 points. For employers whose reserve ratio is low, age and pay-roll variations are considerably more important. Yet they may be thought sufficiently important to constitute a distinct modification of the reserve-ratio plan of experience rating.

In Montana the law authorizes the Commission administering the law to apply "such form of classification or experience rating system which is best calculated to rate individually and most equitably the employment for each employer and to encourage stabilization of employment." This gives the Commission power and direction. A limitation is imposed by another provision of the law which requires the Commission to give consideration in its plan to annual net percentage declines in taxable pay rolls for the preceding three years, the number of years the employer has paid taxes under the system, and benefits charged to the employer's account. These three must be considered "to an equal extent." Since the ratio of benefits to contributions is considered, this plan combines reserve ratio and pay-roll variation, but without heavy emphasis on the former, and both modified by the firm's age. The rates that may be applied to individual employers begin at a low of 0.5 percent and increase by 0.2 percent steps to a maximum of 2.7. However, the law provides that the rates applied must be such that the total amount yielded shall be approximately 1.2 percent of the preceding year's total taxable payroll. And no employer whose contributions in the three preceding years amounted to less than the benefits paid to his workers may receive a reduced rate.

Experience rating plans that do not directly relate the individual employer's experience with his tax rate appear to have a serious weakness. In such plans employers have no direct incentive to contest unjustifiable claims for unemployment benefits. They have little incentive to help police the system.

Guaranteed Wages. The Social Security Act permits deductions from the Federal Unemployment Tax by employers who have guaranteed wage plans if the state law permits such plans under conditions that meet Federal minimum requirements. Seven states incorporated the Federal provisions in their acts. All but one had repealed those provisions by the end of 1946. No state ever authorized rate reductions to any employer under those provisions. The first Wisconsin law, enacted before the Social Security Act, per-

mitted reductions for employers with guaranteed wage plans. More than 90 employers had such plans. But the conditions did not meet the minimum Federal requirements, and when Wisconsin brought its conditions up to the Federal minimum, nearly all existing plans were discontinued. For the country as a whole there were approximately 200 guaranteed wage plans covering some 61,000 workers in January 1946, and the number has been increasing. But lower contribution rates do not therefore accrue to their sponsors.

Fund Protecting Provisions. All experience-rating states make general and some of them make special provisions to safeguard their reserve funds for paying benefits. Rates of taxes levied on employers are related either directly or indirectly to the condition of the reserve fund as well as to the unemployment experience of the employer. It should be added that during the war twelve states levied "war risk" contributions on employers whose pay rolls exceeded specified amounts or in some cases on the entire pay roll, which were usually substituted for the rates normally charged. In most instances the rate charged was 2.7 percent of taxable pay roll. This was done to protect the fund against anticipated heavy claims.

The most common method used to safeguard the fund is to specify that when the state fund reaches a "danger point" defined in terms of benefits, pay rolls, or number of dollars, no employer will be taxed at a rate lower than 2.7 percent of his taxable pay roll. Usually when benefits are used as a criterion, the provision is that rates shall not be reduced at all unless the amount in the fund exceeds the amount of benefits paid in the preceding calendar year. The margin of safety in the benefit criterion is not large unless the fund is already sufficiently large to carry a heavy burden for several years. Some states specify an absolute amount which the fund must have before lower rates may be granted. The dollar criterion can hardly be considered satisfactory until the state's system has become stabilized. A few states use pay roll as a criterion, the pay roll for the preceding year, or an average of five or 10 years. When the fund falls below a specified percentage of the pay roll, say 3 percent, no rate reductions are to be allowed. Some states combine several of these criteria and require that the fund at least equal the higher of the two or highest of the three.

A second method of fund protection is to vary individual rates in accordance with the size of the fund rather than to prohibit any reduced rates at all. When the fund reaches a specified danger point,

some or all rates are increased either by the same percentage amount or according to a schedule of rates.

A third, and indirect method, used when there was a substantial number of employer-reserve with supplemental pool laws, is to transfer sums from reserve accounts to the pool. When the pooled account falls below the danger point, which is in all cases a specified number of dollars, specified percentages of pay rolls, either for a preceding or subsequent period of time, are transferred from the reserve accounts to the pooled account. Since individual tax rates are related to the ratio of reserve to pay rolls, these transfers by reducing the reserves will result in some employers paying higher taxes.

Approximately 20 percent of the states authorize or require reductions in benefit rates whenever the solvency of the fund is jeopardized. This is a fourth method. Should this method be used, it will mean that workers are deprived of some protection at the very time they need it most, since the solvency of the fund would be jeopardized only in periods of heavy and prolonged unemployment. When the fund reaches the danger point, benefits may be reduced either by a specified percentage or in accordance with a schedule, or the maximum number of weekly benefits payable may be reduced or the waiting period increased, or other eligibility conditions changed.

In Maine, if the Commission finds that benefits could be increased without imperiling the fund's solvency, it shall increase weekly and annual benefits, but not to exceed 20 percent, and vice versa.

EMPLOYEE CONTRIBUTIONS

Nine states have at one time or another required employee contributions. The spread of experience-rating plans and the marked growth of reserves have led most of them to abandon employee contributions, and only two states have continued to levy them for unemployment compensation.

The Federal government made small contributions to the District of Columbia fund during its first three years. No other state has contributed, except a few which have made relatively small contributions to help defray part of the administrative costs. The question of state or Federal contributions was never a lively one and there are no indications that it will become so in the near future.

ADMINISTRATION

The Federal government pays all the necessary and proper costs of administering state unemployment compensation laws. Funds for this purpose are secured from that part of the Federal Unemployment Tax which may not be offset, i.e., the 10 percent. The 10 percent collected by the Federal government, it should be noted, is not earmarked for unemployment compensation administration and it goes into the general fund. The Congress determines how much money is to be appropriated for administration, and it is under no obligation to appropriate any given amount or proportion of the amount collected. Grants are then made to the states by the U.S. Department of Labor through its Bureau of Employment Security. The conditions which must be met in order to qualify for these grants have been described in Chapter 10.

Special Administrative Funds have been established in many states and these are not subject to the control of the Federal government. The money comes from various sources, usually from interest and penalties on past-due contributions, although in some states special legislative appropriations are made. The funds are used: (1) for administrative costs not properly chargeable against Federal administrative grants or other funds; (2) to replace Federal administrative funds lost or spent for nonapproved purposes; (3) as revolving funds to be used in advance of, and later to be replaced by, Federal administrative grants; and (4) to refund interest and penalties erroneously collected.

The Bureau of Employment Security of the U.S. Department of Labor carries out the Federal functions. Every year it passes upon all laws and certifies to the Secretary of the Treasury those which conform to Federal requirements, in order that employers in those states may receive normal and additional tax credits; it passes on state budgets and handles the grants for administrative expenses, and it assists states with their rules and regulations, and in other ways. The Social Security Administration has regional offices in each of which there is a Bureau representative and assistants, who are constantly in close contact with the states.

Administration expenditures of the state compensation agencies are audited by the Bureau of Accounts and Audits, which also advises in regard to accounting and financial procedures. The Bureau

of Employment Security collects statistics from the states and advises with them on statistical and research problems. Legal assistance is provided by the Administration's legal staff. The Bureau of Internal Revenue collects the Federal tax, that part of it which is not offset against state taxes. The Treasury Department manages the Unemployment Trust Fund.

Slightly more than one-half of the state acts are administered by independent security agencies which are separate and distinct from any other state department. In slightly less than one-half of the states, the administrative body is part of the labor department, industrial commission, or workmen's compensation commission. In about 40 percent of the states, there is a single responsible administrator. In the remainder there is a Board of three or more. In most of these, the Board members serve full time, in some only one member serves full time, and the others draw *per diem* for time served. In a few all Board members serve part time.

Some states have Advisory Councils composed of nonsalaried representatives of employers, workers, and the public, whose stated function it is to advise the administrators.

Every state has a system of state public employment offices, supported in part by the Federal government through grants made under the authority of the Wagner-Peyser Act, the grants being based on population but with a minimum grant for each participating state. Both the public employment offices and the compensation system are usually under the direction of the commission or commissioner, but each is a separate division or bureau with its own head. Within each of these two major divisions are the numerous departments each charged with the task of carrying on a part of the complicated work of paying benefits.

The state unemployment compensation agency actually administers the law. One of the agency's most important functions is to maintain an accurate record of workers' earnings, and in some states also the length of employment, for it is upon these that eligibility, weekly benefit amount, and duration are based. Two methods of getting this information are used. Most of the states require current reporting quarterly of each employee's total taxable earnings for that quarter. Some use the separation reporting plan in which wage and other information for a one- or two-year period is reported for any worker only after he has become unemployed. A few states use both methods, requiring quarterly reports from some and separa-

tion reports from others. Current reports result in better wage records, but separation reports entail less expense to employers and the state.

The procedure centering around the payment of benefits is carefully outlined. The first step in the procedure is for the unemployed worker to file a claim for benefits, which he does on a special form and usually at the public employment office in his neighborhood. In sparsely settled regions, some other public office may serve or an itinerant public employment service is provided.

The claim for benefits is then usually sent to the central office to determine whether the individual has met the qualifying conditions of employment or wages. If he has, the weekly benefit amount and potential duration of benefits are determined. Decisions relating to availability for work and possible disqualifications are mostly determined by the local office. In some states, local offices make most of the determinations, subject to review by the central office.

Workers receiving benefits are required to appear regularly, usually once a week and at varying times of the day, at public employment offices as an indication that they are still unemployed and available for work. Benefits are generally paid by check mailed through the postal system although in some states claimants get their checks in local employment offices.

Contested claims are handled in several ways. Most laws provide that they may be disposed of either by a full-time examiner acting alone or by a board of three, one of whom is an examiner and the other two representing employers and employees. Only a few states include workers on local appeal boards. A few states provide for the examiner, but do not permit the alternative of a joint board. Appeal is permitted from the decision of the examiner or board, usually to the unemployment compensation commission but sometimes to a permanent board of review. A few states provide for direct appeal from the deputy to the commission administering the act. Many states permit the deputy handling claims to refer doubtful cases directly to the appeal body, and some require that all cases involving a labor dispute be so submitted.

Decisions of the administrative appeal bodies are subject to review by the courts, beginning with the county or district court and then to the state supreme court. However, the courts are permitted to pass only on questions of law and not of fact. That is to say, the administrative tribunals make certain findings of fact which must

be accepted by the courts, as for example, whether the worker was in covered industry, the time of his employment, amount of wages, and so forth. Whether the administrative body correctly interpreted and applied the law, however, is another question, and one which the courts may pass upon.

CHAPTER TWELVE

STATE UNEMPLOYMENT COMPENSATION ACTS: OPERATIONS

THE American system of unemployment compensation, if it can be called a system, is still in the developmental stage and has not as yet been subjected to a severe test of adequacy. Benefits were not payable for several years after the dates of original enactment, in order that small reserves might be accumulated. Then preparations for defense and later war and intense postwar activities all made for a prolonged period of full employment, increasing wages, large tax revenues, and small benefit expenditures. It is true that approximately 12 million war jobs were terminated between Germany's defeat and one year following the collapse of Japan. But reconversion to civilian production proceeded at an amazing rate and new jobs developed almost as rapidly as old jobs were terminated. Furthermore, the Federal Servicemen's Readjustment Act cushioned the shock of demobilization and took something of a burden off state unemployment compensation funds. This favorable experience made it possible to develop operating techniques and to build up financial reserves against darker days expected to come. Operations to date are described below, necessarily in rather general terms.

COVERAGE

Although coverage is far from being universal, steady progress has been made in extending the scope of American acts. Numerical limitations have been reduced in many states, some additional employments have been included, and there has been a steady growth in the number of workers engaged in covered employment.

Numbers in Covered Employment. The average number of workers in employment covered by state acts in 1938 was about 20

million, and it averaged slightly more than 23 million in 1940. In 1944, the number reached 29.8 million, an increase of almost 50 percent over 1938. A large part of the increase was brought about by the growth of war industries, which employed many boys and girls of school age, married women who were normally housewives, and men who had postponed their retirement, persons in other words who would normally not be in the labor force. Postwar expansion has further increased the number. For 1952 the average was 35.6 million, an increase over 1938 of approximately 78 percent. Coverage will unquestionably continue to increase. In 1952 there were more than 1.5 million active employers.

Not all of the workers in covered employment are protected by state laws. Many of them are excluded by numerical limitations. Manufacturing, for example, is an employment included within the scope of all state laws, but many of the acts apply only to employers of specified minimum numbers, usually eight or five. It has been estimated that approximately 3 million workers are excluded by these numerical limitations.

The percentage of wages and salaries in covered employment to all civilian wages and salaries was 61.5 in 1938, increased to 72.2 in 1943, then declined slightly, but was up to 73.5 in 1952. Expansion of income outside the system was greater between 1944 and 1946 than within the system.

Occupational Distributions. Table 31 shows the occupational distribution by industry division of all workers in covered employment and their total earnings for 1951.

The distribution of employment among industry groups varies from year to year and may change markedly over a decade or less. Most workers are in manufacturing and trade—74.7 percent in 1945 and 70.0 percent in 1951. The proportion in manufacturing rose from 45.6 in 1939 to 56.3 in 1944, and was 45.7 in 1951. Wholesale and retail trade have shown increasing percentages for some time; they accounted for 24.3 percent in 1951 as compared with 21.8 in 1945. Contract construction is quite erratic. In 1945, because of the war, it accounted for only 3.5 percent; in 1951, however, it accounted for 6.6 percent.

Payroll percentages reflect the distribution of workers among industry groups. Manufacturing and trade combined accounted for 75.2 percent of total wages in 1945 and 70.4 in 1951. Appreciable increases in wages occurred in building construction, where there

was little activity during the war. In trade, wages increased more between 1945 and 1951 than did employment. In 1945 wages from trade amounted to 18.3 percent and to 21.7 in 1951. Changes in other categories in recent years have been small.

TABLE 31. Unemployment Compensation. Covered Employment and Total Earnings, by Industry Division, 1951 ¹
(In Thousands)

Industry Division	Employment		Earnings	
	Average	Percent	Average	Percent
Total	34,858	100.0	\$118,717,346	100.0
Agriculture, forestry, and fishing	75	0.2	214,397	..
Mining	894	2.6	3,517,214	3.0
Contract construction	2,304	6.6	8,972,789	7.8
Manufacturing	15,940	45.7	57,782,659	48.7
Transportation, communication, and other public utilities	2,624	7.5	9,220,444	7.8
Wholesale and retail trade	8,467	24.3	25,745,669	21.7
Finance, insurance, and real estate	1,592	4.6	5,379,279	4.5
Service industries	2,907	8.4	7,744,392	6.5
Miscellaneous	55	0.1	140,503	

Covered employment shows a heavy concentration in highly industrialized states. Nearly one-half, 48.3 percent, of all covered employment in 1951 was in six states—New York, 12.7, Pennsylvania, 9.1, California, 7.9, Illinois, 7.0, Ohio, 6.7, and Michigan, 4.9. The six states having the smallest percentage in 1951 had a combined total of less than 1 percent—Alaska, Nevada, North Dakota, South Dakota, Wyoming, and New Mexico.

The exclusion of agriculture from the scope of state acts affects very few workers in the industrialized portions of the country, but in such states as Arkansas, North Dakota, and Mississippi the exclusion affects more than half of the gainfully occupied. The exclusion of domestic service affects a larger proportion of women than of men. And both affect Negroes much more than whites. The New York act, which applies to employers of four or more domestic servants, covers about 3500 domestic workers, which is about 10 percent of the state's household workers, and probably more than

¹ *Labor Market and Employment Security, Statistical Supplement*, September, 1952.

are to be found in any other state. In 1945, California permitted self-employed persons to elect coverage, charging them the full employer rate of 2.7 percent and the employee rate of 1 percent. At the end of the first year, not a single self-employed person had elected coverage and only 10 or 12 had made written inquiry about it.²

Numbers with Wage Credits. Figures on average employment do not show how many different individuals were at one time or another during the year engaged in covered occupations. The number of different individuals working for covered employers is considerably larger than the average working for them at any one time, and especially over a period of two years. A better measure of coverage is the number of workers with wage credits, i.e., workers on whose wages employers paid some taxes.

In 1939, the number of workers with wage credits was estimated at 30 million. In 1943, the number reached 44 million, an increase of nearly 47 percent, but declined to an estimated 42.5 million in 1945. In 1951 there were 45.8 million. These were workers on whose wages employers paid some taxes.

Not all workers with wage credits become eligible for benefits, however, for all laws specify certain wage requirements for eligibility to benefits, both for minimum and maximum benefits. In 1945, an estimated 36 million workers, or 86 percent of the total with wage credits, had credits enough to qualify for at least minimum benefits.

The percentage of new claimants for benefits who did not have sufficient wage credits to qualify for benefits has been estimated for different years, beginning with 1940.³

1940	16.0	1944	9.9
1941	16.4	1945	8.7
1942	14.5	1946	12.9
1943	13.4	1947	14.9

CLAIMS AND BENEFICIARIES

The process of paying benefits begins when the unemployed worker files a claim, which is designed to establish his right to receive benefits and to mark the beginning of his waiting period, and in some states of his benefit year. This is called the "initial" claim.

² *Social Security Legislation*, Hearings before the House Ways and Means Committee, 79th Cong., 2nd Sess., Vol. 3, p. 1480.

³ *Social Security Yearbooks*

If benefits are granted, then for each additional week of unemployment the worker must file a "continued" claim, which is the basis on which benefit payments are continued from week to week. If a worker becomes reemployed, his benefits cease. But if he later in the same year again becomes unemployed, he must file an "additional" claim. A few states do not require additional claims, and their reports on initial claims therefore somewhat understate the number of separations.

Number of Claims. Comparable data on claims for all states exist only beginning with 1939. Table 32 shows numbers of claims filed by years. Initial claims here include additional claims subsequent to reemployment.

TABLE 32. Unemployment Compensation: Initial and Continued Claims, by Year, 1939-1947, 1952 ⁴

Year	Total	Initial	Continued	Ratio of Continued to Initial
1939	66,298,484	9,764,758	56,533,726	5.8
1940	77,816,085	11,140,012	66,676,573	6.0
1941	50,868,646	8,526,993	42,341,845	5.0
1942	40,085,828	6,323,881	33,761,762	5.3
1943	9,548,780	1,884,096	7,664,684	4.1
1944	7,343,423	1,502,802	5,480,621	3.6
1945	36,682,636	6,048,909	30,633,727	5.1
1946	77,177,621	9,844,425	67,333,196	6.8
1947	61,429,000	9,702,000	51,727,000	5.3
1952	65,485,000	11,174,000	54,311,000	4.9

The year 1940 was the high-water mark for claims filed until 1949, when there were 120.3 million. The figures for 1939 and 1952 are probably much more representative of what will usually occur than are any of the others. The smallest number of initial claims recorded in any month was 90,361, and the peak prior to the postwar readjustment was about 1.5 million. A marked increase in the number of claims filed set in when hostilities ceased in August of 1945, and again in the recession of 1949.

The rapidity with which workers who lose their jobs get new ones is measured by the ratio of continued to initial claims. In 1944

⁴ *Social Security Yearbook*, 1945, pp. 79, 80, *Social Security Bulletins*.

reemployment, as measured by this ratio, was almost twice as rapid as in 1940, the ratio being 3.6 as against 6.0. The rate of reemployment slowed down substantially in 1945 and 1946. In these years, many marginal workers were laid off. Many of them found it difficult to secure new jobs, and some made no attempt to do so. Not all unemployment by covered workers is reflected in these figures, it should be noted. For many workers are discouraged from filing when it is apparent that they are not eligible for benefits. The ratio of continued to initial claims in 1952 was 2.1.

Number of Beneficiaries. The number of persons who receive benefits is obviously much smaller than the number filing initial claims or even the number of eligible claimants. For many claimants either get jobs before receiving any payment or have their claims denied. Table 33 shows the numbers of eligible claimants and beneficiaries through 1947. In 1943 and 1944, somewhat less than half of those filing claims got on the benefit rolls. Indeed, many who were let out did not even file, but got new jobs immediately. For 1947, more than a third filing claims drew no benefits.

TABLE 33. Unemployment Compensation: Claimants and Beneficiaries, 1940-1947 ⁵

Year	Eligible Claimants (Millions)	Beneficiaries (Millions)	Ratio of Bene- ficiaries to Eligi- ble Claimants
1940	6.1	5.0	85.7
1941	4.5	3.4	76.9
1942	3.6	2.8	78.7
1943	1.1	0.7	61.1
1944	0.9	0.5	57.5
1945	4.0	2.8	70.7
1946	5.7	4.5	78.9
1947	6.2	4.0	64.5

The year 1940 was still one of considerable unemployment, despite the substantial recovery that had taken place. There were more than 6 million eligible claimants and benefits were paid to more than 5 million. Industry was becoming unsettled as a result of the war in Europe, and American defense preparations were just getting under

⁵ *Social Security Yearbook*, 1945, p. 86, *ibid*, 1946, pp. 22, 25; *Social Security Bulletins*.

way. The record in 1941 and 1942 was much better. The peak of employment was in 1943, when our economy was going full blast. In that year there were only 1.1 million eligible claimants and only about 700,000 beneficiaries. Most of those losing jobs quickly got others. September of 1943 showed the lowest number of initial claims on record to that date, namely 90,361. The year 1944 was even better in so far as unemployment compensation operations are concerned. But the tide turned heavily in 1945, when nearly 3 million were again on the rolls, and it became worse in 1946, when there were approximately 4.5 million beneficiaries, but improved some in 1947. In 1952 there were 11,174,000 initial claims.

Perhaps a better indication of the benefit load is the average weekly number of beneficiaries, shown by years in Table 34.

TABLE 34. Unemployment Compensation: Average, High, and Low Weekly Number of Beneficiaries, by Year, 1940-1947 ⁶

Year	Average, Year	High		Low	
		Number	Month	Number	Month
1940	982,392	1,268,566	June	666,636	December
1941	621,065	825,748	January	430,016	October
1942	541,495	837,650	February	192,573	December
1943	115,454	226,778	January	56,354	November
1944	79,306	112,156	March	63,273	September
1945	466,550	1,323,168	December	87,243	April
1946	1,150,217	1,641,732	January	700,074	November
1947	847,573	1,006,000	June	593,441	November

The yearly average declined steadily through 1944 and then turned upward again with the ending of the war. Reconversion proceeded rapidly in 1946, but not without an appreciable amount of unsettlement in the labor market, more on the average than in any year since 1939. The weekly average number of beneficiaries reached a new peak of 1,666,000 in 1949 and was 1,305,000 in 1950. A decline then set in, and for 1952 the average was 873,600, about one-half the number in 1949. The high month has usually had about twice the number of beneficiaries as has the low month, but 1942 and 1943 are marked exceptions.

During the war years there was a "core" of unemployment, made

⁶ *Social Security Yearbook*, 1946, p. 25; *Social Security Bulletins*.

up mostly of seasonal and "marginal" workers. There were many women, older persons, and physically handicapped people who had been attracted to or retained in employment because of the great need for labor. Raw material shortages and priority orders also affected the operations of many employers. Another factor involved was that in these years numerous states reduced their waiting periods and thus made it possible for more people to qualify for benefits.

BENEFITS

Except in Wisconsin where benefits were first paid on August 17, 1936, no state paid benefits until January 1938. Reserves were built up for two years after contributions became payable. In 20 states benefits did not finally become payable until 1939.

Total Benefits. The total amount paid out in benefits through December 1952 was \$9230 million. For 1936 and 1937, payments were exceedingly small, amounting to \$2.1 million. Benefits became payable in 30 additional states in 1938. The sharp business recession that came late in 1937 resulted in heavy benefit expenditures, \$393.8 million in 1938, and \$429.3 million in 1939 when benefits were payable in all states. The year 1940 was even worse, and benefit payments amounted to \$518.7 million. Defense and then war resulted in some diminution in benefit payments, but 1941 and 1942 payments exceeded \$344 million each year.

A drastic decline then took place, beginning late in 1942, and benefits for 1943 amounted to only \$79.6 million, and for 1944 were even lower, namely \$62.4 million. October and November of 1943 mark the low point in the wartime decline, payments amounting to only \$3.5 million each month. Wyoming paid no benefits at all in September of 1943.

Benefit payments then slowly began to climb again. As victory over Germany and Japan became reasonably certain, readjustments were made in war production. In January of 1945, benefits amounted to \$7.3 million and in July they were almost double that amount. In September of 1945 they exceeded \$50 million and were more than double that in each month in the last quarter. The total for 1945 was \$445.9 million. Benefit payments exceeded the billion-dollar mark in 1946, 1949, and 1950. Increased coverage and benefit rates will make billion-dollar totals normal.

There are some indications that a very substantial amount of money is being paid out to subsidize the wages of seasonal workers. Furthermore, it appears that a substantial proportion of those workers are in the higher-wage brackets.

Size of Benefits. Statutory provisions set maximum and minimum limits to the size of weekly benefit amounts and to the total amount that any one person may receive in a year. There have been

TABLE 35. Unemployment Compensation Weekly Compensation Rates for Total Unemployment, by Year, 1938-1947 ⁷

Year	Number of Weeks Compensated (Thousands)	Percentage of Weeks Compensated in Amounts of					Average Weekly Benefit
		Less Than \$5	\$5 00-9 99	\$10 00-14.99	\$15 00 or More	\$20 00 or More	
1938	38,076		.				\$10 94
1939	41,554	4.9	40 3	29 0	25.8		10 66
1940	51,084	4.7	39 0	29.2	27.1		10.56
1941	32,295	2.9	36 0	30 6	30.5		11.06
1942	28,156	1.3	25.2	29 7	43.8		12 66
1943	6,004	1.2	15 9	25 8	57 1		13.84
1944	3,724	0 4	8 2	18 3	73 1	28 5	15 90
1945	23,031	0.1	2 3	7 9	89.7	63 9	18 77
1946	58,196	0.1	2.8	10.9	86 3	62.4	18 50
1947	42,000	0.1	4 4	16 6	78 8	54.8	17.83
1952	45,777	. . .	.....	.			22.79

marked variations in the size of the average weekly benefit payment made within these limits, as data in Table 35 show.

It is a striking fact that the average weekly unemployment benefit has been and remains small, although it is increasing. Beginning at \$10.94 in 1938, the average increased to \$18.77 in 1945, dropped to \$17.83 in 1947, and again increased to \$22.79 in 1952. The trend toward higher benefits began in 1941 and was consistently maintained until 1946. There was an increase of slightly more than 25 percent in the average from 1941 to 1943, and a more marked increase of 36 percent from 1943 to 1945, and a total of 72 percent from 1938 to 1945. Increasing weekly hours plus higher wage rates and overtime, together with changes in laws which raised both

⁷ *Social Security Yearbooks*

minimum and maximum benefits payable, account for this upward trend. They account also for the marked increase in the percentage of weeks of total unemployment compensation at \$15 or more, which in 1945 amounted to 89.7. Nearly 64 percent were compensated at \$20 or more in 1945, and nearly as many in 1946. The marked declines in average weekly benefit and percentage compensated at \$20 or more in 1947, despite liberalized rates, full employment, and high wages, are accounted for mainly by changes in the beneficiary group from those in wartime to those in peacetime occupations.

Until 1944, few states paid the statutory weekly maximum for as much as one-half of their total unemployment. By 1944, 58.5 percent of total unemployment compensated was at statutory maximums and 4.4 percent at the minimums. For 1945, the respective figures were 75.6 and 1.3, and for 1946 they were 70.4 and 2.0. In 1947, only 56.7 percent was compensated at statutory maximums and 3.2 percent at the minimums. The declines for 1946 and 1947 reflect primarily the increased maximum rates legislated in those years. In 1946, Alaska was the highest in percentage of weeks of total unemployment compensated at the statutory maximum, with 96.1, and North Carolina was the lowest, with 12.7. North Carolina retained its lowest rank in 1947, with 6 percent, but Nevada took first place with 88 percent. In 1944, only 10 states had statutory minimum benefits of less than \$5, and no state except North Carolina wrote as much as 9 percent of its checks for that amount. The percentage of new insured claimants compensated at the statutory maximum in the fiscal year ending in June 1952 was 57.6.

Duration of Benefits. Statutory provisions limit the maximum duration or amount of benefits payable during a year to any one unemployed individual. Always some receive the maximum. But only in times of widespread and prolonged unemployment will large numbers actually receive the potential maximum.

Estimated average duration of benefits for specified years is shown in Table 36. These estimates are arrived at by dividing the total number of weeks compensated by the number of first payments made, and are thus averages for all beneficiaries and not for those who exhausted their benefits or for the eligible or insured population. For the country as a whole, the average has been surprisingly steady, considering variations in the volume of employment, and has ranged from a low of 7.7 weeks in 1944 to a high of 12.6 weeks in 1946. In 1947, the average duration was down to 11.3 weeks.

This steadiness has continued. Since 1947, average duration has fluctuated between 10 and 12, and for 1952 it was down to 10.4. A business recession, such as the one which began late in 1953, will increase duration somewhat.

TABLE 36. Unemployment Compensation: Estimated Average Duration of Benefits, in Weeks, 1941-1947, 1952 ⁸

Year	Average	High State	Low State
1941	9.4	13.8	5.8
1942	10.0	13.1	5.5
1943	9.0	12.6	4.9
1944	7.7	11.4	5.1
1945	8.2	11.2	3.3
1946	12.6	17.6	5.9
1947	11.3	13.6	7.0
1952	10.4	13.1	7.3

Variations as between states are great, as is shown by the figures for the high and low states. Duration has in general been fairly consistently high in Southern states and low in Northeastern states. But only a few states have been either consistently above or consistently below the national average.⁹ For 1946, average duration of benefits was the same in states with uniform duration laws as in those where duration varies with earnings. But for 1952 states with uniform duration generally had higher averages, and the highest state, with 13.1, was among these.

The average actual duration in weeks for beneficiaries not exhausting their benefits was 6.2 in 1945, 9.0 in 1946, and 8.2 in 1947. For those exhausting their benefits, duration in weeks was 13.8 in 1944, 15.5 in 1945, 18.5 in 1946, and approximately 18.5 in 1952.

Exhaustions. With any given set of statutory provisions, the total number of beneficiaries who exhaust their benefit rights will obviously vary primarily with the condition of the general labor market. During times of good business there will be relatively few layoffs, many job openings, short periods of unemployment, and consequently relatively few exhaustions. However, prolonged un-

⁸ *Social Security Yearbooks*

⁹ For the years 1941-1945, Alabama, the District of Columbia, Georgia, Kentucky, and South Carolina had benefit durations higher than the national average, and Alaska, Arizona, Arkansas, Connecticut, Hawaii, Indiana, New Hampshire, Oregon, West Virginia, and Wyoming had lower durations.

employment in certain occupations will also sometimes exert marked effects.

Exhaustion ratios are computed which represent the exhaustions for a calendar year as a percent of the first benefit payments made to individuals for the 12-month period ending in September of that calendar year. Such ratios are shown in Table 37, for all states with comparable data, and for the highest and lowest states.

TABLE 37. Unemployment Compensation. Exhaustion Ratios, by Year, 1940-1947 ¹⁰

Year	Ratio of Exhaustions to First Payments		
	All States	High State	Low State
1940	50.6	73.0	25.8
1941	45.5	64.4	19.7
1942	34.8	66.0	16.3
1943	25.5	43.1	2.6
1944	20.2	51.2	7.0
1945	16.6	79.6	3.4
1946	38.2	73.8	12.1
1947	30.7	65.6	11.8

The exhaustion ratio of all states combined was high in 1940 when more than half of the beneficiaries collected the maximum amount of benefits due them. In that year there were 2.6 million exhaustions. The ratio for subsequent years declined steadily, reaching 16.6 in 1946. Because the number of beneficiaries on the rolls declined drastically, the absolute number of beneficiaries exhausting their benefit rights declined even more. In 1945, when the ratio was only one-third of the 1940 figure, the number of persons drawing full benefits was only 268,635, or about one-tenth as many as in 1940. Defense preparations and war production account for the trends.

In 1946, the exhaustion ratio increased to 38.2, which was more than twice as large as in 1945, and the number of persons involved increased to nearly 2.0 million, or almost 7.5 times as many as in 1945. It is surprising that in a year characterized by such intense business activity so many persons should draw their full benefits. The explanation given is that a large portion of the beneficiaries were "emergency" or "marginal" war production workers who after

¹⁰ *Social Security Yearbook*, 1947, p. 30.

being laid off found it difficult to secure reemployment. It is probable also that, as in the railroad unemployment insurance system, a substantial number did not want reemployment and proceeded to draw out as much in benefits as they could. It could not be claimed with much reason that the high exhaustion ratio of 1946 reflected inadequacy in the duration of benefit provisions of state laws. There was a marked decline, to 30.7 percent, in 1947, when only 1.27 million exhausted their benefits.

In subsequent years the rate was also low. For the fiscal year ending in June 1949, with March 31 being the twelve-month cut-off date, the ratio was 27.0, but it increased to 32.0 in the following year, and then dropped sharply to 24.2 in the year 1951. For the fiscal year ending in 1952 it was 20.1. The recession of 1954 increased the exhaustion ratio appreciably.

The ratios given above are mostly for years of intensive business activity. A study of Michigan's experience covering a sample of 55,260 workers for July 1938 to July 1939 throws some light on what happens during a period of business recession.¹¹ Nearly half, 45.8 percent, of those receiving benefits exhausted their benefits before being reemployed, and more for women, 61.9, than for men, 42.9. Furthermore, most of those exhaustions occurred early in the benefit year—more than 80 percent at least four months, more than 70 percent at least six months, and nearly 19 percent at least eight months, before the new benefit years began. The lowest percentage of exhaustions, 33.1, was among automobile workers, and the highest, 88, was among apparel manufacturing workers. A larger proportion of workers with relatively unstable employment exhausted their benefits than was true of workers with more stable employment, as would be expected.

Benefits and Job Openings. There was never a week during the war when there was no one drawing unemployment compensation benefits, although in September of 1943 Wyoming paid no benefits whatsoever. Even during the period of most intensive activity, when manpower shortages were seriously hampering the war effort, some were drawing benefits. During the period of reconversion and the intensely active period following, many people drew benefits while at the same time some employers were frantically

¹¹ Paul L. Stanchfield, "Adequacy of Benefit Duration in Michigan, 1938-1939," *Social Security Bulletin*, September 1940, pp. 19-28.

seeking labor, and it frequently occurred that the intense demand for labor was in the same community in which large numbers were on the benefit roll. To many, it seems strange that such could be the case, and the old arguments that unemployment compensation would make people thriftless and lazy and hinder their movement from depressed areas and occupations again appeared in force. This phenomenon is not something which has appeared for the first time with the advent of unemployment compensation, but it has long existed and is inherent in any free, complex, and changing economy, as students of the labor market well know.¹²

A study of claimants for compensation and job openings in three cities—Atlanta, Georgia; Columbus, Ohio; and Trenton, New Jersey—for the nine weeks ending October 6, 1945, throws considerable light on why benefits are paid while job openings exist in the same locality.¹³ Nearly all of the claimants involved were of “working age”—less than 5 percent being under 20 years of age and less than 10 percent over 65. Most of them came from wartime skilled and semiskilled jobs, while openings were predominantly for unskilled. The claimants were mostly women, while most of the openings were for men only. Job openings were listed for fewer than 54 percent of the number of women benefit claimants. More than 40 percent of the openings for women were in clerical, sales, and service occupations, while fewer than 18 percent of the women claimants had such skills. The same situation existed generally for men, but there was a closer relationship between the prewar skill, or lack of it, and the requirements of job openings. Rates of pay in job openings were appreciably lower than applicants’ wartime jobs—yielding about 40 percent less take-home pay for men and about 50 percent less for women.

During the war years there was a great deal of “upgrading” of the labor force. Some workers actually acquired new skills, although relatively few did so, and on balance there was probably a net loss of skill. Many were promoted to better-paying jobs. To some extent, upgrading was used as a device to evade permissible wage ceilings. Accustomed to high earnings, many who lost their jobs preferred to “look around” a bit before taking available work at lower pay. A reasonable period of time allowed to make necessary

¹² See Don D. Lescohier, *The Labor Market*, The Macmillan Company, 1919, especially chap. 1.

¹³ Marvin Bloom and F. Bernard Miller, “Claimants and Job Openings in Three Cities,” *Social Security Bulletin*, November 1945, pp 7-10.

adjustments will normally result in a more economic allocation of the labor force, although it creates a certain amount of what is called frictional unemployment.

During the war years also many "marginal" workers were employed, such as the handicapped, older persons, women and new entrants, people who were employed intermittently and released at the earliest possible moment. Many of these were eligible for benefits and proceeded to draw them. Marginal workers are constantly being weeded out of the economy. Less intense war production activities also resulted in fewer shifts per day and as a result many women who were laid off found it difficult to take available jobs on the other shifts and at the same time carry on essential home duties. These constituted what might be called a special class of marginal workers.

It must be borne in mind that many who are available for work are not in the localities where job openings are listed, and that frequently transportation facilities are inadequate. Adam Smith long ago observed that man is perhaps the most difficult baggage to move. Really strenuous efforts were made to induce workers to migrate to localities where they were needed, and with considerable success. But many would not migrate. "Workers," said the chairman of the Social Security Board, "are not like checkers which can be moved from one square to another in the twinkling of an eye. They are not interchangeable parts that fit into any job, anywhere, any time. They are human beings with widely varying skills and experience and personal situations."¹⁴

Thus differences in skills and sexes required and available, discrepancies between rates of wages offered and formerly received, inadequate transportation facilities between jobs and workers, and the existence of marginal workers account for the coexistence of job opportunities and unemployment, especially in times of great or rapid changes.

Yet it must be admitted that malingering is also a factor. Some beneficiaries would take available jobs if they were not able to draw unemployment compensation benefits. Some have used such benefits to finance, in part at least, a vacation. Considering that unemployment compensation benefits are not subject to income or withholding taxes, they are sufficiently large to satisfy some worker

¹⁴ *Social Security Bulletin*, November 1943, p. 3

for a period of time. Some workers who lose their jobs and never intend to go back into the labor force have no scruples against taking as much in benefits as they can get.

In general, this petty cheating, if it may be called such, has not reached alarming proportions. The vast majority of workers would much rather have a job than receive unemployment benefits. It would be as unreasonable to condemn the entire system because of petty cheating as it would be unreasonable to deny the existence of such cheating. Much of it can be eliminated by "tightening up" the administrative machinery a bit. But some of it there will be in any system in any country at any time. And it will be worse in abnormal than in normal times.

DISQUALIFICATIONS AND APPEALS

Disqualifications. There are four major basic grounds for disqualifying an unemployed worker from receiving benefits: (1) quitting his job without good cause, (2) refusal to accept or apply for suitable work; (3) discharge for misconduct, and (4) participating in a labor dispute. All laws have had these basic disqualifications from their inception.

Quitting work without good cause is and should be adequate reason for refusing to pay benefits. But good cause is a very elastic concept. In January of 1940, only four states limited this ground to "good cause attributable to the employer" or to the employment. By the end of June 1947, it was so limited in 17 states. Workers who leave their employers for better jobs or because of transportation difficulties, as many did during the war, or for family reasons such as caring for sick children, are in these states disqualified. There were even instances where men who quit to join the armed forces but who were rejected for physical reasons were held to have left without good cause, although steps were quickly taken to eliminate this species of legal and administrative stupidity. This trend was definitely away from the idea that unemployment compensation is for workers who are unemployed through no fault of their own and toward the idea that compensation is for those whose unemployment is a fault of the employer or of the employment.

Refusal to accept suitable work is also a reasonable disqualifying ground. But here too there was increasing severity in its application during the war years. There has been a tendency to broaden the con-

cept of what constitutes suitable work and thus to compel people either to forego benefits or to accept jobs at lower skills or pay, or jobs which involve considerable personal hardship. It has happened that persons disqualified for quitting a job were later again disqualified for refusing to accept that same job.

Discharge for misconduct is a method of disciplining recalcitrant workers that is essential in any free economy. Yet the tendency has been to broaden the concept to include misconduct not directly related to the employment and where the off-job misconduct does not affect performance on the job.

Not only has there been a tendency to disqualify more workers for the same causes and even to increase the number of causes, but there has also been a strong tendency to extend the duration of the period for which the disqualification is imposed. In January of 1940, 43 states provided that the period of disqualification should be one or more weeks. In 1944, only 38 states specified one or more weeks and 13 specified nine or more weeks. Only seven provided in 1940 that the disqualification should extend for the duration of unemployment, and by January of 1944 the number had been increased to 13. And in those states where there are specified limitations, say from three to 10 weeks, administrators have tended to apply the maximum or considerably more than the minimum.

Furthermore, the tendency has increasingly been to deduct the weeks for which a worker is disqualified and the amount of benefits he would otherwise have received from the maximum number of weekly benefits and the maximum amount of annual benefits to which he would otherwise have been entitled. In January of 1938, there were eight states which canceled or reduced the benefits of those who quit without good cause, were discharged for misconduct, or refused to accept or apply for suitable work. The number had increased to 28 by January of 1944, and remained at that figure through 1945, but was down to 24 by the end of June 1947.

The primary cause for this trend toward severity and its justification was the critical man-power shortage existing at a time when there was a vital national need for more production and when employers had opportunities for profit limited primarily by an inadequate supply of labor. The passage of that condition with the ending of the war accounts for the trend toward liberalization of disqualification provisions which set in during 1945.

Disqualifications should continue only for the period during

which the original disqualifying act continues to be the basic cause of unemployment. A worker, for example, who refuses to accept suitable employment may well be disqualified for as long as suitable employment is available. But if and when there is no longer any suitable employment which can be offered, the disqualification should end.

For the fiscal year ending in 1952 the total number disqualified was reported as 1,160,736—slightly more than for 1950–1951 but about one-fifth less than the 1,432,751 for 1949–1950. The most important class of those refused benefits was made up of persons “not able or not available” for work. There were as many as 496,427 of them, or 42.8 percent of the total number. “Voluntary quits” was the next most important cause, and this was the issue in 352,211 cases, or 30.3 percent of the total. Misconduct ranked third in importance; it accounted for 106,616, or 9.2 percent of the disqualifications. Last of the four major causes was refusal to accept suitable work; 92,732, or 8.0 percent, were disqualified for this reason. The rest were refused benefits for various minor reasons.

Appeals. Whenever a worker filing a claim is denied benefits, he has the right of appeal. Table 38 gives percentage figures on appeals disposed of by lower appeal authorities, by source and outcome, for 1941–1947.

Substantial numbers of cases have been decided by lower appeal bodies. The total reached an annual peak of 212,934 in 1947 and then declined until 1950. For the fiscal year ending in June 1952 there were 148,111 decisions. In terms of the number per 1000 initial determinations, there has been a marked and almost constant upward trend. The index rose from 9.2 in the last six months of 1941 to a peak in 1944, and then after a brief decline resumed its upward trend, reaching 51.8 for the fiscal year ending in 1952.

Nearly all of the cases reviewed have been appealed by employees, about 90 percent until 1946, when the percentage dropped to 84.3, reflecting a more aggressive attitude on the part of employers.

A substantial proportion of claimant appeals have been modified in their favor, showing that in general it has paid to appeal, but there was a distinct downward trend during the war, which was one manifestation of increasing severity in the treatment of unemployed workers. There was also during those years an increase in the percentage of employer appeals not modified against the claimant's interest.

TABLE 38. Unemployment Compensation Appeals Reviewed by Lower Appeal Authorities, by Source and Outcome, by Year, 1941-1947 ¹⁵

Year	Dispositions per 1000 Initial Determinations	Claimant Appeals		Employer Appeals	
		Percent of Total	Percent Modified in Claimant's Favor	Percent of Total	Percent Not Modified Against Claimant's Interest
1941 ^a	9 2	90 4	46 3	9 6	58 3
1942	10 3	89 4	45 6	10 6	57 8
1943	27 2	93 6	36 8	6 4	54 3
1944	40 7	93 2	31 6	6 8	62 3
1945	24 8	88 3	37 1	11 7	75 0
1946	26 8	84 3	33 4	15 7	61 3
1947	35 3	83 8	29 7	16 2	32 0

^a Last six months

The relative importance of different issues involved in appeals varies considerably with the state of the labor market, as would be expected. Availability for work, which is not listed as a disqualifying factor but as a condition of eligibility, was the issue involved in 22.5 percent of local appeal cases in the last six months of 1941, but increased steadily to 44.0 percent in 1945, and then declined slightly, to 38.1 in 1946. Refusal of suitable work was the issue in only 7.6 percent in 1941, but increased to 21.6 percent in 1945, and then declined sharply to 11.3 in 1946. During the years of good employment, workers were not quick to accept anything offered, although available jobs were abundant. To some extent, the large increases reflect increasing severity in the administration of the acts during the war. For both of these the percentage was up slightly in 1947, to 42.2 and 11.7 respectively.

Normally, quitting without good cause would be an issue of increasing importance in good times. But from 1941 to 1944 it declined from 21.6 to 16.6 percent, which is explained by the War Manpower Commission controls over movements, by high wages, and in part by patriotic motives. It was up in 1945, to 19.0 and up still more, to 22.8, in 1946, but declined to 19.7 in 1947 despite a record volume of employment. Labor disputes as an issue varied er-

¹⁵ *Social Security Yearbooks*

atically, from 8.0 in 1941 to 9.7 in 1942, to 2.6 in 1943, then up to 8.8 in 1944, down to 5.0 in 1945, and up to 15.3 in 1946, then down again to 11.7 in 1947. Strikes were not a serious problem during the war.

Misconduct was the issue in 6.6 percent of the local appeals in 1941, 3.9 in 1944, 7.1 in 1946, and 7.8 in 1947. Issues of coverage and wage credits, which also are not classed as disqualifying factors but as conditions of eligibility, have declined to almost nothing because employment has been full and earnings high. Coverage as an issue declined from 12.7 percent of the total in 1941 to 0.7 in 1946, and wage credits from 11.7 to 0.7.

A substantial number of appeals passed on by lower bodies undergo further review by higher appeal authorities. Table 39 shows the source and disposition of such cases for several years.

TABLE 39 Unemployment Compensation: Appeals Reviewed by Higher Appeal Authorities, by Source and Outcome, by Year, 1941-1947 ¹⁶

Year	Dispositions per 100 Cases from Lower Appeal Authorities	Cases Reviewed			
		Claimant Appeals		Employer Appeals	
		Percent of Cases Reviewed	Percent Modified in Claimant's Favor	Percent of Cases Reviewed	Percent Not Modified Against Claimant's Interest
1941					
6 mos	"	67.1	27.5	32.9	72.4
1942	14.4	68.3	33.3	31.7	56.1
1943	19.3	83.5	26.0	16.5	67.3
1944	17.9	89.2	24.8	10.8	74.2
1945	12.9	84.0	24.1	16.0	76.0
1946	11.2	87.6	21.6	12.4	70.3
1947	14.3	90.0	22.5	10.0	58.9

* Comparable data not available

The percentage of all cases reviewed by higher appeal authorities which originated with claimants rose steadily from 67.1 in the last 6 months of 1941 to 89.2 in 1944. The year 1945 saw a substantial decline, but in 1946 the percentage again increased, to 87.6. This

¹⁶ *Social Security Yearbooks*

trend no doubt resulted from the increasing severity of local authority determinations during the war, and the reduction in percentage from 1945 is the result of increased aggressiveness by employers interested in additional man power rather than benefit savings. Claimants did not fare so well with higher authorities as they did with the lower, the percentage of claims modified in their favor being considerably lower. However, the trend toward increasing severity was not as marked in the higher as it was in the lower bodies, the percentage of appeals modified in the worker's behalf falling from 27.5 to only 21.6, as compared with a decline in local bodies from 46.3 to 33.4 in 1946. After the war, claimants appealed in larger proportions and were somewhat more successful in securing favorable modifications and in preventing unfavorable modifications on appeals by employers.

Availability for work, wage credits, and refusal to accept suitable employment accounted for about the same proportions in higher as they did in lower appeals; labor disputes and misconduct were less important. Voluntary leaving was appreciably less important in higher appeals, and coverage was appreciably more important. This suggests that local appeal authorities have not shown much, if any, improvement in their handling of the more technical aspects of unemployment compensation.

INTERSTATE CLAIMS

One striking characteristic of the American economy is its large volume of migration. Because of defense and war activities, migration for a few years exceeded all previous records. The United States Census Bureau estimated that in March of 1945 more than 15 million civilians were living in counties different from those in which they were living in December of 1941, and that half of these, or nearly six percent of the total population of the country, had moved to a different state. Reconversion made for additional movement, but a surprisingly large number of persons remained in their new locations.¹⁷ Some workers live in one state and work in another. Thus many workers who accumulate benefit rights in one state are in some other state when they become unemployed and claim benefits.

¹⁷ Bureau of the Census, *Civilian Migration in the U.S., December 1941 to 1945*, Population—Special Reports, Series P-S No. 5, September 1945. Quoted in *Social Security Bulletin*, January 1946, p. 3.

Claims Machinery. Machinery has been established for handling interstate claims. Workers file claims in the state in which they are located, which acts merely as an agent. Claims filed in one state against others are forwarded to the liable state, which makes all the decisions. If allowed, the benefits as provided by the state against which the claims are made are then paid through the state in which the beneficiary is located.

A seven-state experiment, designed to develop a better procedure, was inaugurated on January 1, 1946.¹⁸ The number of states participating had increased to 19 by the end of 1948. The agent state transmits the initial claim to the liable state, which makes the original determination of eligibility and benefit rights. The agent state pays the benefits, makes all subsequent determinations on eligibility and disqualifications, and is reimbursed by the liable state.

Claims and Payments. A substantial number of interstate claims and payments were made during the years 1940-1942, while migrant workers were being fitted into the war economy. They then declined drastically until postwar reconversion took place. Table 40 gives summary data on interstate claims and payments.

The volume of continued claims involving interstate payments has

TABLE 40. Unemployment Compensation: Interstate Claims and Benefits, by Year, 1940-1947¹⁹

Year	Weeks Compensated		Benefits Paid		Continued Claims	
	Number (Thousands)	Percent of Total	Amount (Thousands)	Percent of all Benefits	Number (Thousands)	Percent of Total Continued Claims
1940	2,141	4 2	\$24,219	4 7		. .
1941	1,803	5 6	21,132	6 1		. .
1942	1,600	5 7	20,778	6 0		. .
1943	478	8 0	6,779	8 5	778	10 4
1944	293	7 1	4,592	7 3	528	9 6
1945	1,039	4 3	19,098	4 2	2,279	7 4
1946	4,872	8 1	89,886	8 2	6,484	9 6
1947	2,168	4 9	38,987	5 0	3,115	6 0

¹⁸ Arkansas, California, Georgia, Louisiana, Minnesota, North Dakota, and Oklahoma

¹⁹ *Social Security Yearbooks*

varied from 6.0 to 10.4 percent of the total. The percentage of total weeks compensated has been lower than the percentage of continued claims, and has varied considerably, from 4.2 in 1940 to 8.1 in 1946. Weeks compensated and amounts paid since 1947 have generally followed the 1945-1947 pattern.

Interstate activities are not uniformly distributed among the different states. Normally every state pays some benefits chargeable to other states. In small, industrial states in highly industrialized regions, workers move in substantial numbers across state lines. Many are domiciled in one state and are employed across the border. Economic readjustments made after hostilities ceased resulted in less industrialized states serving as agents for substantial numbers of their citizens who had accumulated benefit rights in other states. In 1946, for example, 74.7 percent of all continued claims in New Mexico were against other states; in North Dakota it was 65.3, and in South Dakota 64.5. In Delaware it was only 3.3, and in New Jersey 3.6.

It should be noted that interstate payments may be made to workers who have moved as many as two years before they receive benefits. In any event, the provisions for paying interstate benefits constitute a decidedly important part of the American unemployment compensation system. For they break down the economic artificiality of 51 separate and distinct systems in what is basically a single economic unit and eliminate one barrier to the freedom of movement as between our different states.

All states except Kentucky and Oregon had, by June of 1945, amended their laws to permit wage combining with other states and the Federal government whereby wages and employment in different states can be combined for the purpose of determining benefit rights. But wage credits are combined only when a worker has sufficient employment and wages in one state to qualify for benefits in that state. In such cases, wage credits earned in other states may be counted to increase the total benefits received. Benefits so paid are not charged to employers' accounts for rate making purposes, and do not therefore affect experience-rating status. Combining wage credits has to date been a relatively minor operation.

FINANCING

The "standard" rate of contribution is 2.7 percent of covered pay roll in all states except Michigan where it is 3 percent. "Penalty"

rates above 2.7 percent now exist in only about one-fourth of the states. In all states there are some employers, usually small ones, who do not qualify for experience-rating and who therefore pay the standard rate. Furthermore, some rated accounts, approximately 7.2 percent in 1945, pay at the standard rate on the basis of their experience. Thus a substantial number of employers pay the standard rate

Experience Rating. In the early years of the movement, there was much debate about the desirability of experience rating. Theoretical honors probably went to those in opposition, but those favoring it have in practice carried the day. There were 17 states with experience rating in 1941, twice that many in 1942, and by 1948 it was in effect in all states.

The percentage of active accounts in states with experience rating had reached 65.4 in 1946, indicating an increasing degree of stability in employing firms. For 1947, the percentage dropped to 53.1, partly because of an appreciable increase in the number of new employers and partly because extended coverage in some states brought in existing employers who will not qualify for experience rating for several years. For 1947, the highest percentage of rated accounts, 63.5, was in manufacturing and the lowest, 37.9, was in contract construction, a highly seasonal industry. Service industries also had a low percentage of rated to active accounts, 46.1.

The percentage of active accounts in states with experience rating which were given lower than standard rates increased steadily from 54.9 in 1941 to 94.7 in 1946, as shown in Table 41. High wartime employment and the postwar boom were responsible. For 1947, however, there was a slight decline, to 93.8, reflecting the heavy benefit payments made in 1946 and 1947. There are marked differences among industries. In 1947, finance, insurance, and real estate had 96.8 percent of rated accounts at less than standard. Contract construction was low, with 86.2, and mining ranked close alongside it with 88.2.

Experience rating has had a marked effect on the rates actually paid by employers and on the amount of taxes collected, as the data in Table 41 show. For all states combined, employers' average contribution rates declined steadily from 2.58 percent in 1941 to 1.4 in 1947, while for employers in experience-rating states the rate declined from 2.17 to 1.4. The figures on reductions in revenue given in Table 41 represent differences between actual payments made

and what would have been paid at "standard" rates, and the cumulative total of \$3577 million by the end of 1947 is impressive. Some speak of this as a "loss" in revenue. So it is, in a sense, but of course it was intended to be that way. It does not follow that the "standard" rate would have remained unchanged throughout these good years had experience rating not been applied. Even with experience rating, the system has generally been overfinanced. For the years 1949, 1950, and 1951 the average employer contribution rate never reached 1.5 percent, and for the fiscal year ending in 1952 the average rate was only 1.64 percent.

In every major industry, each rate bracket has some employers represented in it, but in each industry the bulk of the accounts are in the lower brackets. For 1947, nearly 58 percent of all rated accounts were in the 0.1-0.9 percent bracket. Two and one-tenth percent of the accounts paid nothing and slightly more than 6 percent paid 2.7 percent or more. Penalty rates were paid by less than 1

TABLE 41. Unemployment Compensation: Tax Rates and Amounts Collected, by Year, 1941-1947 ²⁰

Type of Data	1941	1942	1943	1944	1945	1946	1947
Average employer contribution rate (percent)							
All states	2 58	2 17	2 09	1 80	1 72	1 42	1 4
Experience-rating states	2 17	1 81	1 85	1 59	1 68	1 38	1 4
Percent of rated accounts with reduced rates	54 9	67 4	74 7	84 5	91 0	94 7	93 8
Contributions collected, all states							
Amount (in millions)	\$1008	\$1139	\$1328	\$1317	\$1162	\$ 912	\$ 1060
Cumulative (in millions)	4207	5215	6354	7682	8999	9911	10 971
Percent of benefits to contributions	34 2	30 2	6 0	4 7	38 4	120 1	73 5
Reduction in revenue on account of experience-rating							
Amount (in millions)	\$54 0	\$269 0	\$401 0	\$561	\$654 6	\$799	\$821
Cumulative (in millions)	630 7	684 8	953 3	1357	1924	2756	3577

percent of all rated accounts. Finance, insurance, and real estate had the highest percentages in the low brackets, with 2.6 percent of its accounts going scot-free and 68.8 percent paying from 0.1 to 0.9 percent. The service industries had only 1.8 percent paying no tax, and public utilities and contract construction each had 1.9 percent. The highest percentage paying 2.7 or more, 13.8, was in contract construction, and mining had 11.8 percent in those brackets.

Changes in experience-rating formulas and differences in basic state economic structures make it difficult to evaluate the relative effects of different types of formulas on rate distributions among em-

²⁰ *Social Security Yearbooks; Social Security Bulletins.*

employers. The effects of different types of experience-rating plans on rates for 1946 are given in Table 42. Data for 1947 show marked reductions in the percent of active accounts rated under all formulas. The percentages rated below standard declined slightly in reserve-ratio and benefit-wage-ratio states and also where these two ratios are combined, but increased slightly in benefit-ratio states and in Connecticut, where the compensable-separations formula is used. There was no change for New York. All formulas result in below standard rates for extremely large percentages of eligible employers. New York's pay-roll variation formula yielded below standard rates for practically every eligible employer, and the benefit-wage-ratio formula did almost as well. These rates were based on extremely favorable employment experience, and the results are just what they were intended to be and should not therefore be surprising.

TABLE 42. Unemployment Compensation Percentage Distribution of Active Accounts Eligible for Modified Rates, Rate Years Beginning in 1946, by Type of Plan ²¹

Type of Plan	Percent of all Active Accounts Rated	Percentage Distribution by Employer Contribution Rate		
		Rate Below Standard	Standard Rate	Rate Above Standard
Total, 51 states	65 4	94 7	4 3	1 0
Reserve-ratio	69 1	90 2	9 0	0 8
Benefit-wage-ratio	57 7	98 7	0 8	0 5
Benefit-ratio	61 3	91 2	3 5	5 4
Combined reserve-ratio and benefit-wage-ratio	78 3	89 6	10.4	0.0
Compensable-separations: Connecticut	79 2	96 1	3 9	0 0
Pay-roll-variation New York	74 7	99 9	0 1	0.0

War Risk Taxes. During the war, large numbers entered covered employment for the first time and pay rolls increased substantially. Potential benefit rights were being established by people

²¹ *Social Security Bulletin*, October 1947, p. 5. For 1947 distributions, see *ibid.*, August 1948, pp. 4-13.

many of whom were certain to become unemployed after the war. There was some fear of this potential liability, especially of the possible effects on tax rates which would result from the payment of heavy benefits. There was also the realization that if higher taxes were levied on war production, employers could recoup those taxes by merely adding them as a part of their war-contract costs. There were in fact some instances in which Army and Navy representatives appeared in protest against proposed war risk taxes.

Altogether 12 states imposed war risk contributions.²² The rates were substituted for the ordinary rate on all or on a part of the subject employer's taxable pay roll except in Ohio where it was added to the normal rate. War risk contributions were collected at uniform rates from all employers in eight of the 12 states and on the basis of the individual employer's experience in the others. The taxes were designed to continue only for the war period, and all but three states made specific provisions for their termination. They were levied on employers whose pay rolls exceeded a specified size, either absolute or in relation to experience-rating taxes or individual reserve accounts. Small employers were exempt from the tax in about half of the states. Some levied the tax on new employers, irrespective of pay roll.

War risk contributions had a relatively light impact on a national scale, because only a few states imposed them. They increased the national average tax rate on employers from 2.04 to 2.09 percent in 1943, from 1.79 to 1.92 in 1944, and from 1.41 to 1.42 in 1946. The effect on average rates in the war risk states was appreciably greater, and resulted in an increase from 1.59 to 1.86 in 1943, from 1.43 to 1.90 in 1944, but only from 1.36 to 1.38 in 1946. They increased the unemployment revenues of the states levying them by \$32.5 million, or 19 percent, in 1943, by \$75.3 million, or 33 percent, in 1944, by \$67.8 million in 1945, and by only \$8.0 million in 1946. Only in Wisconsin, however, was the yield enough to offset the lower rates resulting from normal experience-rating provisions.²³

It was thought at one time that experience with war risk contributions might well lead to permanent adoption of the idea of taxing large pay roll increases in order to offset unemployment benefit

²² Alabama, Florida, Georgia, Illinois, Iowa, Kansas, Maryland, Minnesota, Missouri, Ohio, Oklahoma, and Wisconsin.

²³ *Social Security Bulletin*, May 1944, pp. 2-8, September 1946, pp. 9-15; August 1948, pp. 13-14.

rights thereby incurred. But by 1948 only four states still had such provisions in their laws.

Unemployment Trust Fund. All unemployment tax money collected by states must be deposited in the Federal Unemployment Trust Fund, where it is credited to the accounts of the states making the deposits. Funds are withdrawn to pay benefits as needed. The changing status of the Fund is shown in Table 43

TABLE 43. Status of State Accounts in the Unemployment Trust Fund, by Fiscal Year, 1936-1953 ²⁴
(In Thousands)

Fiscal Year	Deposits	Interest Credited	Balance at End of Period	Ratio of Benefits Paid to Deposits and Interest
1936-1937	\$ 291,703	\$ 2,737	\$ 312,389	.
1937-1938	747,660	15,172	884,247	23 5
1938-1939	811,251	26,837	1,280,539	53.0
1939-1940	859,864	37,524	1,693,163	53.8
1940-1941	892,023	45,893	2,093,736	46 1
1941-1942	1,095,991	61,998	2,883,654	31 9
1942-1943	1,217,686	75,563	4,002,570	13.6
1943-1944	1,349,307	88,526	5,380,403	4.5
1944-1945	1,256,003	113,140	6,679,108	5.2
1945-1946	1,009,909	130,373	6,690,672	95 6
1946-1947	1,005,273	131,419	7,009,547	73.4
1947-1948	1,007,346	147,076	7,365,839	65 6
1948-1949	984,031	160,033	7,282,730	107 3
1949-1950	1,098,795	149,046	6,651,571	150 6
1950-1951	1,362,629	147,662	7,313,592	56 8
1951-1952	1,438,987	167,441	7,919,742	62 3
1952-1953	1,371,105	184,242	8,562,537	58 7

Each fiscal year through 1943-1944 saw an increase in the amount collected in taxes, with a peak of \$1349.3 million being reached in the fiscal year ending 1944, and that despite the lowered rates made possible by experience-rating operations which began in 1941. Thereafter a decline set in, owing first to war production cutbacks and later to reconversion and to lower tax rates. Interest payments

²⁴ *Social Security Yearbooks* and *Social Security Bulletins*.

have increased steadily, rising from \$2.7 million in 1936-1937 to \$184 million in 1952-1953. In the fiscal year 1952-1953, the interest received from investments amounted to approximately 14 percent of the amount collected in taxes. The total amount of interest received in the 17 years ending 1952-1953 was \$1684.9 million. The ratio of benefits paid to deposits and interest declined drastically after 1939-1940, reaching the almost incredible figure of 4.5 in 1943-1944. The year 1945-1946 marked a turning point, the ratio reaching a peak of 150.6 for the recession year of 1949-1950, after which came more "normal" rates.

The total reserve of \$7.4 billion available at the end of June 1948 was truly impressive. For the country as a whole it amounted to above 10 percent of covered annual wages. It amounted to almost three times the total amount of benefits paid by all states since the inception of their systems. It was also enough to pay \$20 per week for 20 weeks to about 17 million workers. It was estimated that benefits for maximum durations could be paid out of available funds for one year to about two-thirds of all workers in covered employment. As of June 30, 1948, the ratio of total benefits paid to total contributions received was 42.9.

Not only was the total reserve impressive, but every state had a reserve adequate to meet any immediately foreseeable need. As of June 30, 1948, all but five states had reserves at least as large as the total amount of benefits they had paid since the inception of their programs, and nearly half of them had at least twice as much.

But the reserves of different states did not bear any close relationship to their respective potential benefit liabilities. Two industrial states, Massachusetts and Michigan, each with about 4.7 percent of all workers in covered employment, had at the end of June 1948 the highest ratio of benefits to contributions, namely 63.0 and 62.6 respectively. At the other extreme was Hawaii, whose ratio of total benefits to total contributions was 9.2. It was estimated that Hawaii could pay out of its reserves benefits for the maximum duration to all workers in its covered industries for two years, but that Michigan could pay the maximum to less than 40 percent of its workers.

The situation became less favorable after 1948, because of the recession that followed. Even so, as of January 1, 1952, the funds available for benefits amounted to 8.6 percent of 1951 taxable wages. It was estimated that 44 percent of all covered workers could be paid

for maximum durations out of funds then available in the reserve. Assuming a uniform duration of 26 weeks and a weekly benefit amount consisting of one-twentieth of high-quarter earnings with a maximum of \$30 and a minimum of \$5, the reserve, if it had been pooled, would have carried 35.7 percent of covered workers. Some states were not so well off. The ratio of funds available to 1951 taxable wages varied from 3.7 in Rhode Island to 13.1 in Kentucky. The average employer contribution rate in four states was 2.7 percent of taxable payroll, the lowest being 0.42 percent.

The recession which began in 1953 resulted in a further drain on reserves. Some states, heavily industrialized, were hit fairly hard. There has been some discussion of a "reinsurance" system for the benefit of distressed states. Should it become necessary, states may now borrow from the Federal account established in the Trust Fund for that purpose.

CHAPTER THIRTEEN

RAILROAD UNEMPLOYMENT INSURANCE

INTERSTATE transportation is an industry that presents many special problems, some of them technical and others personal. For one thing, it involves considerable movement of employees across state lines, much more so than in most other industries. Fully as important, however, is the feeling among the more highly skilled workers and their unions that they should be treated as a unit in matters relating to social insurance. As a result, a separate unemployment insurance system has been established for the industry.

THE BACKGROUND

The movement for an unemployment compensation plan for workers in interstate commerce dates back before the Social Security Act was passed. The Railway Labor Executives' Association, an organization of the principal officers of most of the major standard railroad unions, adopted a proposal in 1933 for a system of unemployment reserves. In his annual report for 1934, the Federal Coördinator of Transportation recommended the establishment of such a system and the recommendation was later concurred in by the Interstate Commerce Commission. The Committee on Economic Security recognized the special conditions of the railroad and maritime industries and in 1935 recommended a separate nationally administered system for those two industries.

However, no such plan was adopted. Interstate transportation was included among the employments subject to the Federal Unemployment Tax, and states were permitted to include it under their acts. They did so, but anticipating subsequent Federal action, most states specifically provided for releasing workers later covered by a national act.

Since many railroad workers perform services in several different states, the problem of localizing their benefit rights within a given state was rather difficult. To avoid conflicts of jurisdiction, complicated legal provisions were necessarily inserted in state laws. Covered employment, for example, was defined as including interstate commerce: (1) if performed entirely within the state, or (2) if performed partly within and partly without the state if the outside service was incidental to the individual's inside service, such as in temporary, transitory or isolated transactions, or (3) if the outside service was not incidental, it was none the less included if (a) the base of operations, or place from which the service was directed or controlled, was in the state, or (b) if the base was not in the state, the service was included if the base was not in any state in which some part of the service was performed, and the individual's residence was in this state; or (4) if the interstate services were performed within the state but not covered by the above provisions they were included if not subject to the act of any other state or of the Federal government, and finally (5) service entirely outside the state was included if not covered by any other state or Federal act if the individual performing the work was a resident of the state and if the compensation authority approved the employer's request that the employee's services be covered by this state's act.

The complexities involved in the coverage of interstate transportation workers by states were considered so great, and the advantages of an independent system appeared to be so attractive, that the movement for a national law gained strength. In March of 1936, the Federal Coördinator of Transportation published a detailed plan, including a draft bill. But the bill was not altogether satisfactory to the railroad unions, which proceeded to appoint a committee to study the problem and draft a law easily understood by the workers and simple to administer. A bill was prepared, but the railroad management would not accept all of its provisions. The Railway Labor Executives' Association decided to sponsor the bill independently. There was some opposition, partly based on fear that an independent act would be the entering wedge for a complete national system, and partly because unemployment was considered to be lower in interstate transportation than in general and removing it from state acts might adversely affect state funds, especially in a few states where interstate transportation bulked rela-

tively large. But the bill was passed by Congress without a single dissenting vote.

The bill was signed by the President on June 25, 1938. Benefits became payable on July 1, 1939. Amendments were subsequently made which simplified administration, made the act more easily understood by workers, and modified the benefit structure somewhat. Provision was made for transferring to the new system the benefit rights which had been accumulated under state acts. Taxes paid to the states by the railroads and others subject to the new act, minus any benefits paid to railroad workers, plus accrued interest were transferred to the new administration. The Act is known as the Railroad Unemployment Insurance Act. Its principal provisions are described below. A brief summary of operations will also be given.

COVERAGE

The Act has the same coverage as the Railroad Retirement Act, as described in some detail in Chapter 6. Briefly, it covers as employers, carriers and their associations, their owned or controlled affiliates, express and sleeping-car companies, traffic associations, etc., and standard railroad unions and their various agencies, including local lodges, divisions, and committees. Still more briefly, it covers the railroad transportation industry. An employer may be covered only with respect to a part of his operations, such as warehousing and freight handling departments. It includes as employees all those in the employ of a covered carrier, officers as well as others, except those engaged in coal mining operations in railroad "captive" mines. Included also are the officers and employees of railroad labor organizations, and their subdivisions, which are national in scope and organized in accordance with the provisions of the Railway Labor Act, and all or substantially all of whose members are employed by covered carriers.¹

¹ Also included are "employee representatives" who are officers or official representatives of railway labor unions not classed as employers under the Act if they are employees of a carrier and represent their membership in dealing with the carrier. Any individual who regularly assists an "employee representative" is considered to be an employee.

B E N E F I T S

The benefit structure of the railroad unemployment insurance system is appreciably simpler than that found in most state acts. The benefit rate is a daily one, contrasted with the weekly rates of state systems. The daily rate is made to depend upon the total amount of compensation received by the individual worker in the base year. One effect of using the daily rate is to eliminate altogether the problem of special provisions for compensating partial unemployment.

The Rate Structure. Individual rates depend upon compensation received in covered employment in the base year. But they vary with wage classes rather than with the exact earnings of individuals. Below are shown the various rates and their corresponding wage classes. In computing the total base-year compensation, amounts re-

Base-Year Compensation	Daily Benefit Rate
\$ 400 to \$ 499.99	\$3.50
500 to 749.99	4.00
750 to 999.99	4.50
1000 to 1299.99	5.00
1300 to 1599.99	5.50
1600 to 1999.99	6 00
2000 to 2499 99	6.50
2500 to 2999 99	7.00
3000 to 3499 99	7.50
3500 to 3999.99	8.00
4000 and over	8.50

ceived in excess of \$350 per month are not counted. The pay received by local union officials, which is relatively insignificant in amount, is not counted as compensation, but any other amounts received in covered employment are counted, including amounts paid for time lost when paid for an identifiable period. Some employers pay workers for time lost on account of industrial injuries. When payment is made for industrial injuries, the employer must indicate the amount that is intended for factors other than time lost, otherwise it will all be considered payment for time lost. Those workers who are not paid \$400 in covered employment in their base

year may count remuneration received in employment covered by state unemployment compensation acts if there are reciprocal agreements between the Board and the states.

Registration Periods. There is no such thing as a waiting period in the railroad system comparable to what is found in the state acts, and the term is no longer included in the amended act. A registration period consists of 14 consecutive days, beginning with the first day for which a worker registers himself as unemployed and ending with the 13th day thereafter, or ending with the day immediately preceding the day for which he next registers at a different employment office, whichever is the earlier.²

The alternative definition of a registration period is designed to meet the needs of workers whose change of employment results in their transferring from the jurisdiction of one claims agent to that of another, and who are required to begin a new registration period with every transfer.

A distinction is made between the first and all subsequent registration periods in any benefit year. In the first period in any benefit year, which runs from July 1 through June 30, benefits are payable only for days of unemployment in excess of seven, and in subsequent periods for days in excess of four. Thus it would be possible for a worker to be unemployed for a total of 156 days and still not draw any benefits, but such an event is highly improbable.

Certain railroad employment practices account in part for the practice of compensating only days in excess of four in any registration period except the first, but the major object of this provision is to avoid the payment of benefits to any worker who has received approximately 50 percent of his normal semimonthly wage.

Suppose, for example, that a worker initiates a registration period on July 1, and assume that the registration period is July 1-14. Let July 1-7 be days of unemployment, and assume that the worker is employed July 8-14. No benefits are payable in this period, since this is his first registration in the benefit year and there were only seven days of unemployment. Before a worker is eligible for benefits, there must be a registration period in which he has been unemployed for at least seven days, and this requirement will have been

² The worker registers *for* the first day of unemployment. This he may do on the day of unemployment or on any of the following days up to and including the fourth business day thereafter. Saturdays, Sundays, and holidays are not considered as business days.

met in our example. Sundays and holidays are not counted as days of unemployment unless the worker is also registered as unemployed on the day before and, excepting at the end of a registration period, on the following day as well. A worker who has not already established a first valid registration period and who changes his place of registration may experience more than seven days of uncompensated unemployment in a fourteen-consecutive-day period.

Duration of Benefits. The duration of benefits is not variable, as is true in so many of the state acts, but it is uniform. Any person qualifying for benefits may receive them for a maximum of 130 days in the benefit year. The absolute maximum amount that any one individual could receive in one benefit year is \$1105, and only the most highly paid could receive that much. Thus it is theoretically possible for benefits to cover about six months of continuous unemployment, counting seven days of noncompensable unemployment in the first registration period and four noncompensable days in each subsequent registration period in the benefit year.

Benefit rates are proportionally higher for low-paid than for other workers. This, and the uniform duration of benefits, was provided partly because seniority practices in railroad employment result in relatively more unemployment among the low-paid and short-service workers. The lowest paid workers are also favored by another provision. If the schedule rate is below 50 percent of the employee's regular rate of pay in his last railway job during the base year, his benefit rate is raised to 50 percent of the pay, but not above \$8 50. There will be few benefit rates below \$6.00. But the total amount of benefits any worker can receive in a benefit year may not exceed his base-year compensation. Because of this limitation, workers whose schedule rates are raised may well receive benefits for less than the maximum of 130 days.

The benefit year is uniform for all employees, and is the fiscal year July 1-June 30. Actually the benefit year begins uniformly on July 1, but ends on the last day of any registration period begun in June if that date is later than June 30. This simplifies administration. The benefits paid for such days of unemployment in July are considered as having been paid in the old rather than in the new benefit year. The base year is also uniform and consists simply of the calendar year preceding the beginning of the benefit year.

The benefits provided by the railroad system are more favorable than those provided by most state acts. The rates, especially for

well-paid workers, and the duration of benefits are decidedly better than the average. The lowest maximum benefit payable in a year to an eligible worker is \$455, which is more than the minimum in most states. The maximum benefit, which is payable only to the highest-paid workers, is \$1105, which again exceeds the maximum usually payable under state acts. No doubt the existence of powerful labor organizations in the railroad industry accounts for the relatively high benefits provided by the act.

Yet in some respects the system is less favorable than most state systems. A worker entering covered railroad employment on January 1 will not become eligible for benefits until July of the following year. The year in which this particular worker enters employment will be his base year. His benefit year will not begin until July of the following year. A low-paid worker entering employment late in a calendar year may not earn the minimum of \$400 required to qualify, and may not therefore become eligible for benefits for more than 18 months. There are probably not many such cases.

Eligibility for Benefits. In order to qualify for benefits, it is necessary that a worker have received during his base year at least \$400 for service in covered employment. This is true even though a worker may not have drawn the maximum amount of benefits to which he was entitled in the preceding benefit year. The right to benefits, in other words, must be established anew every year.

This simple eligibility requirement, together with the wage-class system, greatly simplifies the administration of the act by making it possible to predetermine benefit rights and decentralize claims administration. To qualify for any given daily benefit rate, it is only necessary that the worker's wages fall within the corresponding base-year compensation class.

In order to receive benefits, it is necessary that one be unemployed, able and willing to work and available for work. He must not be receiving pay for the time lost. Any worker unemployed at his regular job will not be considered employed if he receives not more than an average of one dollar a day for work in noncovered occupations, and if that work requires substantially less than full time and can be performed without interfering with the holding of a normal full-time job in some regular covered occupation. These earnings are called "subsidiary remuneration," and to be considered as such must be directly traceable, or "ascertainable," to a particular day or particular days. Thus earnings of farmers and merchants

cannot usually be definitely identified with any particular day or days. If such earnings cannot be so identified, they are not considered "subsidiary remuneration" and hence do not in themselves disqualify one for benefits, no matter how large the earnings. However, such earnings may raise the presumption that the individual is not ready and willing to work, and benefits may be denied him unless he can convince the Board that he is available for work.

A person is considered willing to work if he makes reasonable efforts to find a job, by advertising or in other ways; if he is in a position to receive notice of an available job; and if his situation does not prevent him from accepting a job. If, for example, a worker loses his job, makes reasonable efforts to find a new one, then goes to work on a small farm which he owns where he can easily be reached and which he can and will turn over to others, say to a brother, if a job opens up, he probably will be considered available for work. A person is able to work when he can perform regularly and in the customary manner the duties of any regular or gainful employment. A worker who is unfit for one type of work, say heavy lifting because of heart trouble, but who can do something else, is considered able to work. Finally, a worker must be willing to work, if the job offered is a suitable one. A worker who is referred to a job but who fails to get it because he deliberately puts himself in an unfavorable light would not be considered willing to work.

Disqualifications. As in all unemployment compensation acts, workers under certain circumstances are disqualified from receiving benefits. If a worker quits his job, then for a period of thirty days he is not considered to be unemployed, unless the Board finds that he quit with good cause. After that period of time has elapsed, he may qualify for and receive benefits.

There is also a 30-day disqualification for unemployed workers who without good cause refuse to accept suitable work offered them, or who fail to apply for a job to which they are referred by the Board, or who fail to report to an employment office if so directed by the Board. An unemployed switchman who was offered a similar job and refused it, on the ground that the work was hazardous, was denied benefits because the normal risks involved in an occupation do not render that occupation unsuitable for one who has had experience in it and is not otherwise handicapped. But a worker who remains unemployed because he refuses to "bump" someone with lower seniority rights, is not disqualified for benefits, because it has

been held that the right to "bump" does not constitute an offer of employment. Nor is an extra man disqualified who refuses a full-time job in another type of work where his earnings would be less than he can reasonably expect to earn as an extra in his present skill.

As in other unemployment compensation acts, no job is considered to be suitable if it is vacant due directly to a strike, lockout, or other labor dispute; if the wages, hours, or conditions of employment are substantially less favorable than the union rate, if there is one, for similar work in the locality; if employment involves joining a company union or requires the worker to resign from or refrain from joining a bona fide union; if the work involves violation of law or the reasonable requirements of the rules or regulations of his union and would therefore subject him to expulsion from his union; or if accepting the job would subject him to loss of substantial seniority rights acquired under a collective agreement between an approved railway labor union and any other employer.

Workers on strike are disqualified for benefits if the strike is in violation of the Railway Labor Act or in violation of the established rules and practices of a bona fide union to which they belong. If the strike is not in violation of that act or of those rules, the workers are not disqualified by it and may draw benefits. Workers unemployed because of a strike but who are not participating in or financing or directly interested in it, and who do not belong to a grade or class of workers employed in the strike-bound establishment are not disqualified from receiving benefits. The payment of regular union dues is not considered as helping to finance a strike.

For making or aiding in the making of false or fraudulent statements or claims for the purpose of causing benefits to be paid, a worker is disqualified for 75 days, as well as subject to criminal penalties. Seventy-five-day disqualifications for fraudulent registration have been imposed in a considerable number of cases, but comparatively few such cases have been recommended to the Attorney General for prosecution. In the fiscal year 1941-1942, for example, only 15 fraud cases were recommended to the Attorney General for prosecution.

Any worker receiving annuity payments or pensions under the Railroad Retirement Act or the Federal Old-Age and Survivors Insurance system, or unemployment compensation, maternity, or sickness benefits under any state or Federal act is disqualified for the

period during which he receives those payments. However, if such benefits are less than the railroad unemployment benefit, the latter is merely reduced by the amount of the former.

A worker who quits in anticipation of otherwise being discharged is held not to have voluntarily left his job, unless it appears that he really did not have reasonable grounds for believing that he was about to be discharged.

A special disqualification exists for one major class of workers. Employees in the train-and-engine service, including hostling and switching in a yard or on the road, dining-car, sleeping-car service, parlor-car and other Pullman-car or similar service, and express service on trains, are limited by labor agreements and established practice in the amount of work they may do in any one month. Employees who perform their maximum amount of work during 14 or 15 consecutive days would be idle during the next period. If they are paid benefits for that idleness, they would in effect be granted a special favor by the Unemployment Insurance Act.

For these workers there is a special disqualification. They are not entitled to benefits during any registration period in which earnings equal at least 20 times their daily benefit rate. Nor will they be eligible for benefits during the second half of any 28-day period in which their total earnings equal at least 40 times the daily benefit rate. Twenty times the daily benefit amount is estimated to equal eight times the daily wage for these workers, and the disqualification thus puts them on the same basis as other workers in so far as benefits are concerned.

Claims. The claims part of the benefit machinery is geared to railroad facilities. The use of railroad facilities rather than public employment offices for handling claims was decided upon in cooperation with employer and employee organizations because railroad facilities parallel the distribution of covered employees, are equipped for the task, and are familiar to employees.

Certain railroad workers, as a rule supervisors and foremen from whom workers usually receive their pay checks, are designated as unemployment claims agents. These agents are not employees of the Railroad Retirement Board which administers the act, but they are employees of and paid by the railroads. They accept registration and claim forms from unemployed workers. When because of the abandonment of railway facilities there is no employee of that kind in a community, leading citizens such as school principals and ministers

are employed, without regard to Civil Service regulations. They are known as Special Claims Agents and are paid 50 cents a claim, the same rate that is paid to railroads.

The employers of claims agents are paid by the Board at the rate of 50 cents per claim, which is less than it would cost to have full-time claims takers on the Board's pay roll, and the amount, according to the findings of the Board, does not exceed the additional cost incurred by the employers. It may be added that claims agents who are employees of covered firms receive no extra pay for performing this service. Claims takers, because recalls of unemployed workers are usually made through them as supervisors, are in a good position to know whether an individual is ill or working elsewhere and therefore not entitled to benefits.

Above the claims agents are countersigning agents, whose occupational rank is also superior to that of the claims agent. The countersigning agent's main task is to assemble claims from the claims agents, examine them for completeness and consistency, and transmit them to the regional office.

Each covered employer distributes annually to each worker a "certificate of service months and wages," prepared by the Board in its Chicago headquarters' office, which lists the employee's wages earned by months for the base year and the total since January 1937, the latter being for use in connection with retirement annuities. This certificate also shows whether the worker has earned the \$400 in his base year necessary to qualify for benefits, and it carries a statement which explains to the worker how he can compute his daily benefit amount.

The unemployed worker makes his claim for benefits on a registration and claim form. Usually the certificate of service months and wages is attached to the application for benefits when it is sent in to the regional office, the worker indicating on the application whether he will accept the regional office's determination of his wages. If he does not accept that determination, he is asked to fill out a special form and the Board will then recheck its records.

There is in the Chicago office a base-year register of all covered workers, and when the certificate of service months and wages is not attached to the claim for benefits, the regional office requests from the central office a statement of wages earned in the base year. In routine cases, benefit rights are determined on the basis of the certificate of service months and wages; in others after an investiga-

tion. When the worker applies for unemployment insurance benefits, he is given information concerning his rights and responsibilities, and also concerning what he must certify to in order to qualify for benefits, i e., that he is unemployed, able and willing to work and available for work, that he knows of the penalties and disqualifications, and that he is not disqualified. The claims agent renders such assistance as may be needed in filling out the forms.

The registration and claim form is kept by the claims agent and the unemployed worker must later appear before him as instructed in order to register additional days of unemployment. Registered workers are required to report in writing whenever a condition exists that disqualifies them for benefits on a day for which they are registered as unemployed.

At the end of a registration period, the registration and claim form goes to the countersigning agent. In sending the claim to the countersigning agent, the claims agent certifies that to the best of his knowledge and belief the statements of the claimant are correct. The countersigning agent certifies that the form was signed by an authorized claims agent and transmits the form to the regional office. Agents may not deny registration facilities to any employee, and they may not attempt to adjudicate any claim.

The regional office certifies the claim for payment to the disbursing office of the Treasury, which with one exception is located in the same city as the regional office. There the claimant's check is made out and mailed to him. If the claim is disallowed by the regional office, appeal may be taken

Appeals. Any worker whose claim for benefits is denied in whole or in part may appeal. The Board reviews the determination and may designate one of its officers or employees to take evidence and make a report and recommendation. If requested by a properly interested party, the Board may hold a hearing, and it may do so on its own motion. The decisions of the Board are final and binding, subject only to review on matters of law. The Board may establish intermediate reviewing bodies if it sees fit to do so, and may permit appeals from them to itself.

In all proceedings before the Board or its subordinate bodies involving claims for benefits, the ordinary rules of evidence used in courts need not be followed. But full and complete records of proceedings and testimony must be kept, and the Board's decisions,

together with its findings and conclusions of law, must be sent to the claimant within 15 days after final determination.

Very few appeals are taken, which indicates that the Act is both simple to understand and well administered. In 1941-1942, for example, only two cases were appealed, one involving the question of availability for work and the other, later withdrawn, voluntary quitting.

Findings of fact or conclusions of law made by the Board in cases involving benefits or refunds and in drawing on funds to pay benefits or refunds are not reviewable by any administrative or accounting officer, employee, or agent of the United States, including the Comptroller General.

Any claimant, or his union on his behalf if it is organized in accordance with the provisions of the Railway Labor Act, may, after all administrative remedies provided under the Act have been exhausted, appeal to the United States Circuit Court of Appeals for the circuit in which he resides, or to the United States Circuit Court of Appeals for the District of Columbia. The Board must then certify and file with the Court a transcript of the record upon which its findings and decision were based. But the findings of the Board, if supported by evidence and in the absence of fraud, are binding upon the Court.

The Court has power to affirm, modify, or reverse the Board's decision. The Court cannot itself take additional evidence, but it may remand the cause to the Board for a rehearing and order the Board to take additional evidence, and the Board may, after having taken such additional evidence, modify its findings of fact and conclusions. The decision of the Court is subject to review as in equity cases.

Court costs, including the cost of service and printing records, are not assessed against the claimant who appeals from a Board decision, except that the costs may be assessed if the Court finds that the appeal was instituted or continued without reasonable grounds. Claimants may be represented by counsel or other duly authorized agent in any proceedings before the Board or its representatives or a Court.

Employers have no right to appeal to the Courts any of the Board's decisions on benefits, despite the fact that only employers contribute to the fund from which benefits are paid. An employer may appeal the Board's decision that it is covered by the Act.

CONTRIBUTIONS

Tax Rates. Until July 1, 1954, employers were required to pay 3 percent on the wages of their employees, but not on wages in excess of \$300. Beginning July 1, 1954, the base was raised to \$350. But because employment and wages were for years extremely favorable, benefits paid out were low and the amount in reserve became huge. At the end of January 1949, the reserve was \$938 0 million.

Beginning January 1, 1948, the accompanying schedule of rates became effective:

If the Balance on September 30 Is:	The Rate for the Following Year Is:
\$450,000,000 or more	0 5 percent
\$400,000,000 but less than \$450,000,000	1 0 percent
\$350,000,000 but less than \$400,000,000	1.5 percent
\$300,000,000 but less than \$350,000,000	2.0 percent
\$250,000,000 but less than \$300,000,000	2.5 percent
Less than \$250,000,000	3.0 percent

If a worker is employed by two or more employers, only a total of \$350 per month is taxable, each employer paying his proportionate share. However, many workers earn small sums working for their unions or on joint committees and although those sums are taxable, the cost of discovering and prorating total taxes is so great that most railroads refuse to undertake the task. The result is that taxes slightly exceed the rate applied. Total wages taxable, it will be noted, are more than the \$3000 maximum prevailing under state acts. Employers may not shift the tax to their employees, and workers do not contribute to the cost.

The money is generally collected quarterly, and by the Railroad Retirement Board rather than by the Bureau of Internal Revenue, and all but a specified portion of it goes to the Railroad Unemployment Insurance Account in the Federal Unemployment Trust Fund and is used to pay benefits and refunds. Payment is made by the Secretary of the Treasury in the amounts and to the persons certified to him by the Board and prior to audit by the General Accounting Office. If the Board so requests, the Secretary must send the checks to the Board for distribution by it through employment offices or in other ways.

Two-tenths of 1 percent of taxable pay roll goes to the Railroad Unemployment Insurance Administration Fund, and is used for paying administrative expenses. This amount is permanently appropriated to the Board, and it is continuously available without further appropriation, which is not the case with the three-tenths of 1 percent of taxable pay roll collected for the state systems. The Board is not required to submit estimates to the Bureau of the Budget or to request appropriations of Congress. Until January 1, 1948, a sum equal to three-tenths of 1 percent of taxable pay roll was available for administration.

At the end of the fiscal year, the Board must transfer from the Administration Fund to the Insurance Account any amount on hand in excess of \$6 million. Substantial sums were so transferred before the amount allowed for administration was reduced. Money deposited in the Unemployment Trust Fund Account and not used for current benefit payments is invested in United States government bonds. The sums collected from carriers while they were under the different state acts, plus interest, less benefits paid to railroad workers by states, have been transferred from the state accounts in the Unemployment Trust Fund to the Railroad Unemployment Insurance Account in that Fund.

The new rate schedule appears to provide an ample margin of safety. Employment could drop substantially below the average annual number during the worst years of the Great Depression and continue at that rate for four or five years without seriously endangering the reserve account. With a tax rate of 0.5 percent, and with benefits and expenditures continuing as of the beginning of 1948, it would take 20 years to reduce the reserve to \$350 million. It appears that for many years to come the tax rate will not need to exceed 0.5 percent.

Type of Fund. In describing state acts, it was pointed out that three types of funds exist: the pure pool, the pool with experience rating, and the employer reserve with supplemental pool. The Railroad Unemployment Insurance system is of the pure-pool type. All employers pay at exactly the same rate, irrespective of the relative volume of their individual unemployment. All funds go into one account for the entire industry, and are intermingled and undivided. And benefits are paid from this fund to employees irrespective of how much was contributed by their individual employers. There is no provision for rating employers in accordance with the volume of

their unemployment and for permitting those with more stable employment to pay less. Rate variations are now possible, depending upon the size of the reserve, but all employers pay at the same rate.

Experience rating was not attempted for several reasons.³ One reason is that those sponsoring the law did not believe in the soundness of the principle. More important, perhaps, was the fact that railroad management has practically no control over the volume of business. Traffic depends upon general business conditions, and employment depends upon traffic. Furthermore, it would be possible for certain strategically situated railroads by routing traffic to influence the volume of employment on connecting lines, and experience rating would enable them to favor certain lines. Eliminating experience rating also simplifies administration. There is no need to charge benefits back to accounts of employers, and there is less of attempts to evade the payment of benefits in order to secure reduced rates.

ADMINISTRATION

The plan is administered by the Railroad Retirement Board, which was established to administer the Federal act providing retirement annuities to railroad workers. The Board consists of three members, one representing labor, one the carriers, and the Chairman who represents the public. Since both the Retirement and Unemployment plans have the same coverage, and since the Railroad Retirement Board was already functioning and well equipped for the task, it was given the administration of unemployment insurance.

The Board has power to issue subpoenas requiring the attendance of witnesses and the production of any evidence before the Board or any of its members, employees, or representatives. Subpoenas may be served and returned by anyone authorized by the Board to do so. And the Board may designate any of its employees or representatives to administer oaths and affirmations, examine witnesses, and receive evidence. In case of failure to obey its subpoenas, the Board does not have power to punish for contempt, but it may request a Federal District Court to require obedience to the subpoena and the District Court is required to issue the order.

There is within the Board a Bureau of Employment and Claims,

³ J W Couper, "The Railroad Unemployment Insurance Act and Unemployment Compensation Administration," *Social Security Bulletin*, August 1938, pp. 12-16.

and a Director of Employment and Claims, directly charged with the administration of the Act. The Board collects the tax contributions and receives wage reports from the carriers.

There are regional offices and directors, nine in 1954, located in the principal railroad centers of the country, with due regard to geographical distribution. These offices direct and coordinate all regional operations and are responsible for the examination, adjudication, authorization, and certification of all claims. Regional offices also receive wage reports from national labor organizations and employee representatives and collect their contributions under the Act. The records of persons receiving notices of benefit rights in one region are kept in that region for the benefit year, no matter where the worker may be. In the event that a worker transfers to another region and makes a claim for benefits, his claim is sent to the region in which his notice of benefit rights was issued.

District offices, approximately 35 in number, with district managers, are located outside the major centers, and there are some 80 field offices located outside district-manager cities, each with its agent in charge. The district and field agent offices process claims, train agents, operate an employment service, make field investigations, and supply information.

The Board itself is located in Chicago. It may appoint advisory councils, composed of equal numbers of public, employer, and employee representatives to discuss insurance and administrative problems and to aid the Board in formulating policies. Members receive a salary of \$10,000 per year.

OPERATIONS

A summary view of the system's operations through 1951 may now be attempted. These were nearly all "good" years, and in truth most of them were decidedly "abnormal." The data do not, therefore, enable us to point out many well-defined trends. But they do give us some understanding of the system's major characteristics as they are reflected in operations.

Employers Covered. Through June 1951, a total of 6611 companies had been held covered by the Act for various periods of time, but many were covered for only short periods of time. The number of employers subject to the Act at any given time is not great, since interstate transportation is characteristically carried on by large com-

panies with many employees Table 44 shows the numbers covered in various fiscal years.

The totals may be somewhat misleading, since they include many small units and also some subsidiaries whose compensation and service data are consolidated with those of their parent companies For 1950 there were 1380 employers operating under the Act Nearly all of these—1076—were carriers, 136 were carrier affiliates, 141 were carrier associations, and 27 were railway labor organizations In addition there were 160 “employing units,” or contractors doing work in interstate transportation for covered employers

TABLE 44. Railroad Unemployment Insurance. Number of Units Held Employers, Through June 1947, by Provision of Act Under Which Covered and by Fiscal Year ⁴

Type of Unit	Fiscal Year Ending June 30							
	1940	1941	1942	1943	1944	1945	1946	1947
Total	1130	1167	1350	1569	1609	1419	1628	1650
Carriers ^a	878	884	1040	1243	1264	1100	1280	1294
Carrier affiliates	106	129	143	154	166	147	167	169
Carrier associations	120	127	140	146	151	148	157	162
Railway labor organizations	26	27	27	26	28	24	24	25

^a Subject to Part I of the Interstate Commerce Commission Act

Railroads represent the most numerous single class. Indeed, Class I railroads are by all odds the most important element in the system. There are only 142 Class I railroads and they constitute only about one-eighth of all active employers subject to the Act, but they employ about 85 percent of all employees covered.

Employees Covered. The number of workers in covered employment by years and taxable pay rolls are shown in Table 45.

Employment increased considerably as a result of defense and war activities, and pay roll increased even more as a result primarily of overtime. The number employed and taxable pay rolls both remained high during the postwar boom But the high level of employment began to decline as the war drew to a close and as the boom wore off and business conditions became more normal for the railroads. Total pay roll has not declined to the same extent because of wage increases.

The bulge in employment coming with the Second World War and the boom following it have now disappeared. For 1948 the

⁴ *Annual Reports of the Railroad Retirement Board*

TABLE 45. Railroad Unemployment Insurance Estimated Numbers and Pay Rolls in Covered Employment, by Year, 1937-1947 ⁵

Calendar Year	Total (Thousands)	Average During Year	Total Taxable Pay Roll (Millions)
1937	1979	1276	\$2186
1938	1597	1090	1951
1939	1642	1147	2100
1940	1693	1194	2226
1941	2045	1322	2629
1942	2562	1470	3250
1943	2825	1589	3887
1944	2966	1671	4218
1945	3085	1678	4317
1946	2701	1619	4620
1947	2415	1600	4742

number of different employees serving during the year dropped to 2,316,000. For 1949 there was a further decline, to 2,090,000, and in 1950 the number was 2,034,000.

Numbers Qualified for Benefits. Not all employees in covered employment are eligible for benefits, for in order to qualify one must earn a specified minimum amount in his base year, which is the calendar year preceding the beginning of his benefit year. In 1942, for example, some 525,000 workers, or about 21 percent of the total, did not earn the qualifying minimum, and in 1947 about 415,000 or 17 percent. The numbers qualified for benefits in the various fiscal years are shown in Table 46.

The increase in the number of workers qualified for benefits resulted partly from full employment, which enabled more to earn the minimum qualifying sum, but even more from the large numbers employed. Fuller employment increased the proportion eligible for higher benefit amounts. Before the war, approximately 80 percent of those employed met the minimum earnings qualification, but because of high turnover the percentage declined to about 65 in 1942-1943. Thereafter it increased again, reaching approximately 74 percent in 1945-1946, and 83 in 1947-1948.

Claims. Claims received since the Act became effective, by specified fiscal years, are shown in Table 46

⁵ *Annual Reports of the Railroad Retirement Board, The Monthly Review*, August 1948, p. 177.

The marked decline in the number of claims received until 1945-1946 reflects the full employment conditions prevailing generally during the war years. Until 1942-1943, the most important single factor affecting the claims load was seasonal fluctuations in employment. Normally, there is little variation in the level of employment during the months of July-October. A sharp seasonal decline usually occurs during November-January, although there is always a flurry of Christmas activity. A continuous and rapid increase in employment exists during February-June, when the maintenance-of-way

TABLE 46. Railroad Unemployment Insurance. Workers Qualified for Benefits and Claims Received, by Specified Fiscal Years

Fiscal Year	Number Qualified	Claims Received
1939-1940	1,284,084	1,441,213
1941-1942	1,403,258	517,394
1943-1944	1,953,324	27,495
1945-1946	2,284,292	847,009
1947-1948	2,270,400	1,346,574
1949-1950	2,046,000	3,731,000
1951-1952	1,857,000	905,000
1952-1953	1,811,000	1,305,000

activities are carried on full blast. But in the fall and winter of 1942-1943, declines in employment were small, because many railroads held their men against spring needs, and employment could not greatly expand in the spring.

The Railroad Retirement Board reports that seasonal and intermittent unemployment benefits in interstate transportation fluctuate inversely with general business activities. When the rate of general unemployment ranges from 7 to 22 percent, a reduction of 1 percent in general unemployment is accompanied by a reduction of one beneficiary per 100 railroad employees. Within this range of 7 to 22 percent, beneficiaries per 100 railroad employees run about four points below general unemployment. Below 7 percent, the reduction in railroad beneficiaries is slower. It should be added, however, that workers with base-year earnings below a statutory minimum, formerly \$150 and now \$400, do not receive benefits.

Beneficiaries. Table 47 shows numbers of beneficiaries by benefit years since the railroad system was established. The system

started out with a substantial number of beneficiaries, because many workers had acquired rights under state laws before the national act became operative. For the first two years, there was little change in number. Then the war brought about a drastic decline. In the benefit year 1944-1945 the total number of beneficiaries was down to 6481, and the ratios to qualified and employed workers became insignificant. Postwar reconversion, the replacement of many "mar-

TABLE 47. Railroad Unemployment Insurance:
Number of Beneficiaries, for Unemployment
in the Benefit Year, by Benefit Years,
1939-1953 ⁶

Benefit Year	Number of Beneficiaries	
	Total	Per 100 Qualified Employees
1939-1940	161,000	12.7
1940-1941	164,000	11.0
1941-1942	75,000	5.3
1942-1943	16,000	1.0
1943-1944	5,000	0.2
1944-1945	6,000	0.3
1945-1946	157,000	7.0
1946-1947	225,000	9.5
1947-1948	210,000	9.2
1948-1949	286,000	13.6
1949-1950	506,000	24.7
1950-1951	181,000	10.2
1951-1952	162,000	8.7
1952-1953	224,000	12.4

ginal" workers with younger and abler persons, and industrial strikes, especially that of the coal miners, brought the total in 1945-1946 back to what it was in 1939-1940. The total number of beneficiaries amounted to 224,000 in 1952-1953. In each year, many of the beneficiaries were persons who established rights to benefits in the preceding calendar year, who had left the railroad industry, and who had lost their jobs in industrial plants.

The occupational pattern of beneficiaries changes from year to year, but the rank of the major groups is pretty well fixed. Of those receiving payments in 1947-1948 for unemployment in that year,

⁶ *Annual Reports of the Railroad Retirement Board*; and issues of *The Monthly Review*

41.9 percent were laborers, and nearly all of those were employed on ways and structures. The second largest group consists of train-and-engine-service employees, who constituted 16.0 percent of the total, the great majority of them being firemen, brakemen, switchmen, and hostlers. Skilled maintenance employees ranked third with 11.5 percent of the total, nearly all of whom were shop workers. Relatively few office employees find their way on the benefit rolls. In 1947-1948 they accounted for approximately 8.4 percent, most of them being clerks and junior stenographers.

Those on the benefit roll were out for an average of 102.8 days in 1939-1940. Beginning with defense preparations, the average declined, reaching a low of 57.1 days in 1943-1944, the year of peak operations. Thereafter it increased again. For 1946-1947, the average was 101. For laborers it was 113, for office employees 106, for helpers and apprentices 96, for gang foremen 80, for skilled maintenance employees 76, and for train-and-engine-service employees 72. Not all of these days were compensable. Nor do they represent all unemployment, for many ineligible workers do not register, nor do those who have exhausted their benefit rights.

Averages do not show the extent to which unemployment varies as between individuals. The following distribution for the year 1946-1947 throws some light on the problem.

29,105, or 14 3 percent,	were out under 20 days
26,448, or 13 0 percent,	were out from 20 to 39 days
21,722, or 10 7 percent,	were out from 40 to 59 days
15,516, or 7 6 percent,	were out from 60 to 79 days
15,658, or 7 6 percent,	were out from 80 to 99 days
11,226, or 5 5 percent,	were out from 100 to 119 days
11,206, or 5.5 percent,	were out from 120 to 139 days
71,992, or 35 4 percent,	were out over 140 days

Most of the 1946-1947 beneficiaries, 73 percent of them, were laid off by railroad employers. About 13 percent, the next largest group, voluntarily quit, largely unskilled and clerical workers. Discharges accounted for 8 8 percent of the beneficiaries. Others got on the roll because of their physical condition, suspensions, and strikes.

Like most other American unemployment compensation systems, the railroad system has not as yet experienced a heavy blow. Table 48 gives data which outline the major characteristics of benefit experience through 1953.

Total benefits certified for payment in the benefit year 1939-1940

amounted to slightly less than \$15 million. Except for a small increase in 1940-1941, resulting from liberalization of benefit rates and duration in 1940, the yearly total declined until it reached the insignificant sum of \$547,000 in the war year 1943-1944. There was a marked increase, to \$20.5 million, in 1945-1946, partly because the war strain had eased somewhat. If the 1945-1946 benefit rates and duration had been in effect during 1939-1940, total benefits in that first year would have been about \$3 million greater than for 1945-1946.

For 1946-1947, a record total of \$46,617,000 was paid in benefits, more than 2½ times as much as in the preceding year. There are several reasons for the increase. The high wartime employment and large turnover in 1945, the base year, resulted in large numbers qualifying for benefits. There was a lower employment level in

TABLE 48 Railroad Unemployment Insurance: Benefit Expenditure, by Benefit Years, 1939-1953 ⁷

Benefit Year	Total Benefits Certified	Amount per Beneficiary	Exhaustions per 100 Beneficiaries
1939-1940	\$ 14,810,000	\$ 94	19
1940-1941	17,699,000	108	17
1941-1942	8,890,000	118	14
1942-1943	1,753,000	108	10
1943-1944	547,000	118	9
1944-1945	728,000	128	11
1945-1946	20,517,000	138	12
1946-1947	46,617,000	226	23
1947-1948	32,426,000	163	10
1948-1949	46,745,000	178	8
1949-1950	113,769,000	236	17
1950-1951	24,780,000	159	10
1951-1952	22,741,000	140	9
1952-1953	53,849,000	246	12

1946-1947, and appreciably larger numbers received benefits. Furthermore, the 1946 amendments liberalized the benefit structure. Two higher daily benefit rates were introduced, \$4.50 and \$5.00, and duration was extended from 100 to 130 days. In effect this raised the maximum weekly benefit from \$20 to \$25 and the duration from

⁷ *Annual Reports of the Railroad Retirement Board.*

20 to 26 weeks. This explains the greatly increased average duration of unemployment from 64 to 101 days. Heavy and fairly prolonged unemployment in 1949-1950 nearly tripled the amount of benefits paid the preceding year, raising the total to \$113.8 million. Rate liberalization introducing higher brackets will result in a higher level of total benefit payments.

The trend in the average amount paid per beneficiary has been upward. Rate and duration increases in 1940 raised the average from \$94 to \$107.65. Thereafter variations were small until 1944-1945 showed a fair increase, with a still more marked increase to \$138 in 1945-1946 and to \$226 in 1946-1947. Since then the average has fluctuated widely.

Each year except 1944-1945 has shown an increase in the average daily benefit rate, accounted for mostly by the higher wages and steadier employment which enabled workers to move up into the higher base-year compensation classes. From an average of \$2.25 in 1939-1940, the daily rate increased to \$3.36, nearly 50 percent, in 1945-1946, and to only \$3.37 in 1946-1947 despite the two higher daily benefit rates introduced in 1946.

Cost of Administration. The cost of administering the Act has been low, much less in fact than the amounts collected for that purpose. Table 49 gives data through the fiscal year 1952-1953.

TABLE 49. Railroad Unemployment Insurance. Administration Fund, by Year, 1938-1948, 1953 ⁸

Year	Total Receipts	Expenditures	Balance
1938-1939	\$ 6,902,491	\$1,596,663	\$ 5,305,828
1939-1940	12,869,644	4,163,743	14,011,730
1940-1941	6,818,035	3,384,449	9,945,316
1941-1942	8,459,142	2,499,836	11,994,955
1942-1943	13,861,959	2,188,279	17,695,336
1943-1944	12,142,009	3,189,431	14,948,214
1944-1945	13,193,483	3,585,614	15,617,970
1945-1946	12,905,443	3,712,553	15,214,985
1946-1947	14,176,038	4,561,181	15,650,101
1947-1948	14,512,264	5,524,425	14,967,357
1952-1953	10,020,000	5,777,000	10,243,629

Expenditures never at any time exceeded 50 percent of the amount allocated to administration, and have usually been much

⁸ *Ibid.*

less. Reducing the amount allocated from three-tenths to two-tenths of taxable pay roll in 1948 has reduced collections. Through June 1953 a total of \$164.8 million was collected for administration and \$58.7 million was spent; this includes annually since 1947 about \$2 million for administering sickness benefits. The ratio of expenditures to benefits has been extremely high, but understandably so because benefits have been abnormally low, the machinery for collecting and recording compensation data had to be maintained, and an employment service had to be provided. In the fiscal year 1943-1944, five-sixths of all expenditures were for the employment service, but for the fiscal year 1945-1946 only 36.2 percent of total expenditures went for the employment service, and only 11.7 percent in 1946-1947. Figures in the balance column indicate amounts collected in excess of expenditures which are unexpended at the end of the period. As noted above, balances in excess of \$6 million must be transferred to the Unemployment Insurance Account in the Trust Fund.

TABLE 50. Railroad Unemployment Insurance: Status of Trust Fund Account, by Fiscal Year, 1939-1953 ⁹

Year	Total Receipts	Interest	Benefits	Balance
1939-1940	\$ 46,261,928	\$ 201,846	\$ 14,809,692	\$ 31,452,236
1940-1941	176,024,492	3,059,433	17,699,137	189,777,591
1941-1942	85,479,317	5,423,137	8,890,442	266,366,466
1942-1943	105,236,128	6,857,073	1,756,106	369,846,489
1943-1944	129,071,063	8,004,733	552,410	498,365,142
1944-1945	138,739,960	10,679,269	737,208	636,367,894
1945-1946	139,513,954	13,298,578	20,514,054	755,367,795
1946-1947	152,630,007	15,374,911	46,617,479	858,762,394
1947-1948	158,424,457	18,280,440	59,030,458	956,282,469
1948-1949	29,141,900	20,118,154	76,568,727	899,116,212
1949-1950	31,503,480	17,873,933	143,256,101	784,718,734
1950-1951	32,908,843	16,593,132	51,783,481	765,832,982
1951-1952	36,240,869	16,459,297	48,639,735	753,434,117
1952-1953	36,316,274	16,415,960	97,375,000	692,375,603

Unemployment Trust Fund Account. As with the states, nearly all of the Railroad Unemployment Tax goes into the Federal Unemployment Trust Fund, credited to the account of the Railroad Retirement Board. As noted before, the unused part of the Administrative Fund is also deposited there. Interest on investments is added. Table 50 shows the status of the account for specified years.

⁹ *Ibid.*

Only \$32.4 million of the \$59.0 million in benefits in 1947-1948 was for unemployment; the remainder was for sickness and maternity.

It was inevitable that taxes resulting from increasing employment and earnings in the defense and war years would yield considerably more than required to pay diminishing benefits. The balance on hand at the end of the fiscal year 1947-1948 was about \$956 million, which was five and six-tenths times as much as was paid out in benefits since 1939. It was enough to pay average benefits for three years to almost 2 million unemployed workers, about as many as the number qualified to receive benefits at the end of that year. The system has been "overfinanced."

In 1946, Congress amended the Unemployment Insurance Act to provide a system of cash disability and maternity benefits. No additional tax was levied, and money to pay those benefits is taken from the Unemployment Trust Fund Account. Furthermore, since 1948 the tax rate will be appreciably lower.

Contributions from employers have been at the minimum rate of 0.5 percent since the variable rate schedule was introduced in 1948. As a result, contributions have been less than expenditures and the balance was reduced to just under \$590 million by the end of June 1954. Contributions will continue at the minimum rate as long as the fund balance remains above \$450 million.

PART FOUR

OCCUPATIONAL INJURIES

CHAPTER FOURTEEN

THE PROBLEM OF OCCUPATIONAL INJURIES

NEVER has there been a time when those engaged in the task of earning a living did not experience dangers to life and limb, dangers which arose out of and in the course of their employment. Eolithic man labored in a rugged and hostile world that grudgingly yielded him a meager subsistence and exacted in return its price in blood and toil; and for countless ages those who followed him fared but little better. The real coin of the realm has always been an alloy of sweat and blood and tears. The price we pay today may be greater or less than was paid by our forebears, but we pay in the same coin.

Industrial accidents are commonplace, so commonplace that normally they do not seriously burden the public consciousness. Most of us become conscious of the problem only when some catastrophe occurs, as when an explosion traps and kills many miners, or when some girls are poisoned by radium used in painting luminous dials for watches, or when someone in our own community or immediate circle of acquaintances is stricken. Of the inexorable toll of life and limb that is constantly exacted in the process of production, we are only dimly and fleetingly conscious.

THE GENERAL PATTERN

It will be worth while to inquire briefly into the existing pattern of occupational injuries in the United States. But only the barest outline can be drawn, for records are not nearly as comprehensive as one would expect them to be. As recently as 1927, the United States Bureau of Labor Statistics reported that although there had

been an immense accumulation of "the raw material of statistics," a good national compilation was impossible. It said:¹

It would appear to be a rather simple matter to combine the records of the several States and so produce a national compilation of much interest and utility. Unfortunately, the States have adopted procedures sufficiently different to make it difficult and in many cases impossible to combine these records in a general exhibit. The primary reason for this is that the State agencies have found themselves so involved in the multiplied problems of compensation that they have been quite unable to give adequate attention to the really more important problems of accident prevention.

There has been some improvement since then, but existing statistics are still inadequate. Many states report only accidents compensable under their workmen's compensation laws, and the scope of such laws is limited and differs from state to state. Substantial numbers of persons are employed in industries outside the scope of workmen's compensation legislation, or are excluded by numerical limitations. For agriculture and domestic service, no system of reporting exists, and data are exceedingly fragmentary and generally unreliable.

Our picture of the nature and extent of such injuries must therefore be built up with fragmentary data and with estimates made by careful and competent statisticians who have utilized all of the important sources of material which are available.

Number and Types. First of all, then, let us look at the total number and major kinds of accidents in order to get some idea of the nature and size of the problem. Table 51 presents estimated numbers of occupational injuries which caused disability lasting for one day or more for a series of years, by type of disability.

The year 1939 marks the beginning of a sharp upward trend in the total number of disabling work injuries, a trend which reached a peak of 2,414,000 in 1943. The upward trend is explained largely by the fact that increasingly greater numbers of persons were employed during that period, which was one of recovery, defense preparations, and war operations. In part the upward trend is explained by a greater frequency in accidents, occasioned by greater intensity of work, by the employment of many "green" hands, who are more likely to become injured, and by a general relaxation of safety precautions which is characteristic of periods of intense

¹ *Handbook of Labor Statistics, 1924-1926*, Bulletin No. 439, p. 213.

activity. The increase in the total number of accidents from 1940 to 1943 was about 27 percent. The subsequent decline in 1944 and 1945, and the increase in 1946 and 1947 are explained on the same general grounds. A total of more than 2 million work injuries in one year is a fairly heavy price to pay for production.

TABLE 51. Estimated Number of Disabling Work Injuries, 1936-1947 ²

Year	Total	Fatalities	Permanent Total Disability	Permanent Partial Disability	Temporary Total Disability
1936	1,407,200	16,000*	..	66,200	1,325,000
1937	1,838,000	19,600*	..	126,000	1,691,700
1938	1,375,600	16,400*	...	98,900	1,260,300
1939	1,603,500	16,400*	. .	109,400	1,447,700
1940	1,889,700	18,100*	.	89,600	1,782,000
1941	2,180,200	19,200*	..	100,600	2,060,400
1942	2,267,700	18,100	1,800	100,800	2,147,000
1943	2,414,000	18,400	1,700	108,000	2,285,900
1944	2,230,400	15,900	1,700	94,400	2,118,400
1945	2,020,300	16,500	1,800	88,100	1,913,900
1946	2,063,100	16,500	1,800	92,400	1,945,300
1947	2,059,000	17,000	1,800	91,800	1,950,200

* Includes permanent total disability cases

Approximately 95 percent of all injuries in these years resulted in temporary total disability, and the ratio of this type to the total number has slowly but steadily increased, although it has probably approached quite near its maximum. All of these workers were in due time returned to production. Conversely, the proportions of permanent disabilities and fatalities have steadily decreased. Fatalities, for which separate figures are available only since 1942, decreased from eight-tenths of 1 percent of all injuries in 1942 to seven-tenths in 1944, then jumped back to eight-tenths the following three years. There does not appear to be a close correlation between fatal accidents and the total volume of employment. For many years now, the trend in fatal occupational accidents has been downward. Two decades ago, estimates of 25,000 or 30,000 killed were commonly accepted, although they probably exaggerated the extent of the problem.

² *Monthly Labor Reviews*

Data given in Table 52 indicate that the number of permanent total disability cases is exceedingly small and that it has remained between 1700 and 1800 in the years for which separate estimates have been made. Though the permanently totally disabled are few in number, their plight is serious, for the remainder of their lives can at best be only comfortable. Permanent partial disability cases have fluctuated considerably in number, averaging about one million annually. The number has varied directly with the volume of employment. The percentage which permanent partial disability cases bear to the total has changed but little since 1941, and has been about 4.5 percent of the total. The percentage may well have reached its irreducible minimum.

TABLE 52. Estimated Number of Disabling Injuries During 1947, by Industry Group (Preliminary)³

Industry Group	Total	Fatalities	Permanent		Temporary Total
			Total	Partial	
All groups	2,059,000	17,000	1,800	90,000	1,950,200
Agriculture	298,000	4,300	400	14,900	278,400
Mining and quarrying	92,900	1,500	200	4,100	87,100
Construction	151,700	2,400	300	4,300	144,700
Manufacturing	539,000	2,700	200	27,200	508,900
Public utilities	27,700	400	"	600	26,700
Trade	360,600	1,500	100	8,600	350,400
Railroads	71,900	800	300	5,000	65,800
Miscellaneous transportation	135,200	900	100	7,400	126,800
Services, government and miscellaneous industries	382,000	2,500	200	17,900	361,400

" Less than 50

These figures, it should be remembered, are for all gainfully occupied persons, including employers and the self-employed. Approximately 80 percent of the total disabilities, somewhat more than 80 percent of the temporary total, and about 90 percent of the permanent and fatal injuries, are suffered by employees. More than half of those not suffered by employees happen to the self-employed in agriculture.

³ *Monthly Labor Review*, March, 1948.

Occupational Distribution. The U.S. Bureau of Labor Statistics published annually the estimated number of disabling injuries for each major industry group, with subtotals by type of injury. Such a distribution, based on preliminary data, is shown in Table 52 for the year 1947. The industry groups listed differ greatly in numbers employed and degree of hazardousness, and the totals must be read with those two points clearly in mind. A fair idea of the relative standing of industry groups is presented by the data in that table.

Manufacturing ranked first in number, with nearly 27 percent of all disabling injuries reported, and its total of 539,000 was appreciably more than the 316,000 reported for the year 1940, and much less than the 786,900 reported for 1944. The war years resulted in a tremendous expansion in manufacturing and a great many inexperienced persons were employed. The need for production overshadowed concern for safety. Trade, wholesale and retail, is more hazardous than many suppose, and ranked second. Here again the principal explanation is the large numbers engaged in the industry. But the handling of heavy packages of goods which finally find their way to the merchant's shelves is full of hazards. Serving the customer in the retail store is not itself a hazardous operation.

Agriculture ranked third, and is always high on the list because of the large number of persons engaged in it as well as because of its many inherent hazards. It is well, however, to accept the totals for agriculture with considerable reserve, for the estimates are based on fragmentary data.

Construction ranked fourth. The number of estimated injuries in construction in 1940 was 453,800, which was considerably more for that year than were estimated for either agriculture or trade.

Among industries, the "killers" stand out in bold relief. Mining and quarrying in 1947 had the highest percentage of fatal to total injuries, namely 1.61 percent. For the miner, death comes frequently, suddenly, and violently. It has long been so, and was at one time worse than it is today. Construction ranked second, with 1.51 percent. Agriculture ranked third, with 1.44 percent. Injuries in agriculture are less adequately reported than in other industries. Railroads came fourth, with 1.10 percent of fatal to total. Public utilities other than railroads, and miscellaneous transportation, ranked low in fatal accidents.

Special occupations have earned unsavory reputations as man-killers. Electric light and power linemen, structural iron workers, bridge painters and steeplejacks, roofers and slaters, and lumbermen and loggers, to mention but a few, are subject to sudden and violent death at their work.

The "maimers" also stand out prominently. Permanent total and permanent partial disabilities combined constituted 7.37 percent of all injuries in railroads, and 5.13 in agriculture. In all other industry groups, the percentage was less than 5.0, the lowest being 2.41 for trade.

It has been estimated that there are about 40 million minor injuries annually which involve either no lost time or less than one day and are therefore not reported. Some estimates are higher. The American College of Surgeons in a study of 390 companies employing 1,400,226 workers found a total of 1,106,289 work injuries in 1936, but only 1 in 40, or 2.5 percent, resulted in lost time, and only 66 percent of these latter disabilities lasted long enough to enable the injured worker to collect workmen's compensation payments. At this rate, the total number of work injuries would be about 50 million annually.⁴

Time Lost. It is inevitable that in a large and hazardous economy the total amount of time lost on account of occupational injuries should be large. In Table 53 are estimates of man-days and man-years lost for the years 1940-1947 inclusive.

The actual time lost indicates the number of days and years that workers injured in the respective years were unable to work in those years on account of occupational injuries. Actual time lost in 1940 and 1941 was equivalent to the work of 140,000 men employed full-time during each of those years. A peak of 190,000 man-years was reached in the tempestuous year of 1943. Thereafter the total ranged between 142,000 and 152,000. Actual man-years lost in recent years represent about .277 percent of our total civilian labor force during those years.

But actual time lost in a year is not a good measure of the burden imposed by occupational injuries. For many are killed, or permanently disabled for life. More than the actual time lost during the year in which the injury occurred should be charged to these

⁴ M. N. Newquist, *Medical Service in Industry and Workmen's Compensation Laws*, American College of Surgeons, 1938, p. 29.

TABLE 53. Estimated Actual and Adjusted Man-Days and Man-Years Lost Through Occupational Injuries in the United States, by Year, 1940-1947 ⁵

Year	Actual Time Lost		Adjusted Time Lost	
	Man-Days	Man-Years	Man-Days	Man-Years
1940	41,912,000	140,000	233,840,000	780,000
1941	42,083,000	140,000	251,000,000	835,000
1942	53,000,000	177,000	263,000,000	880,000
1943	56,800,000	190,000	274,000,000	914,000
1944	43,614,400	145,000	222,944,000	743,000
1945	45,600,000	152,000	231,264,000	771,000
1946	42,750,000	142,000	230,000,000	765,000
1947	44,700,000	150,000	233,700,000	780,000

cases. Standard time charges have been developed, and they are described later in this chapter.

Actual time lost and standard time charges for all but the purely temporary disabilities combined constitute what is here called adjusted time lost. This is a better measure of the time lost because of any one year's occupational injuries. Estimates for the various years are given in Table 53. Roughly it may be said that each year's injuries cost us the equivalent of three-fourths of a million men working full time. The totals are more than five times as large as those for actual time lost. Adjusted man-years lost in recent years represent about 1.4 percent of our total civilian labor force for those years.

A word of caution is in order. As will be noted below, standard time charges may well exaggerate the number of man-days lost as a result of certain kinds of injury. Furthermore, except during periods of the fullest employment, an injured worker's place is generally taken by someone who would otherwise not have been employed. Even so, the burden remains great.

FREQUENCY AND SEVERITY RATES

The figures given above are raw totals, and because they are not related to the number of persons employed and the amount of time worked they are not very useful for more refined analysis. Measures

⁵ U. S. Bureau of Labor Statistics

that take account of the number of hours of exposure to hazards have been developed. In Germany, where the problem was first attacked, the number of days actually worked times the number employed was divided by 300 to get the computed number of full-year workers, and multiplied by 1000 to get an index number. This method was used for a time by the United States Bureau of Labor Statistics. However, the International Association of Industrial Accident Boards and Commissions agreed to use hours of employment instead of man-years. Two measures were established, one to express frequency and the other severity.

Frequency Rates. The frequency rate expresses the number of lost-time injuries, that is the injuries which involve a loss of working time over and above the day or shift on which they occurred, per 1,000,000 man-hours of exposure, or work. It may be stated as:

$$FR = \frac{I \times 1,000,000}{MH}$$

where *FR* is the frequency rate, *I* the total number of lost-time injuries, *MH* the total number of man-hours of exposure, and 1,000,000 a constant factor.⁶ It may be expressed roughly as the number of injuries for every 500 full-time workers. The time period used is generally a calendar month, quarter, or year, but the rate may be computed for any period for which data are available. Thus a firm that in any one year employs 1000 workers for 50 weeks of 40 hours and has 14 "lost-time" accidents will have a frequency rate of 14 times 1,000,000 divided by 2,000,000, the number of hours of exposure, which equals 7.0. In other words, the firm will have experienced 7 lost-time accidents per million man-hours of exposure.

There are some who consider the frequency rate to be "the most important single measure of both the accident trend and the size of the accident problem. . . ."⁷ It may be used by an employer to determine where accidents are occurring in his plant, to compare

⁶ For seamen, 100,000 man-days are used instead of 1,000,000 man-hours, because. "(1) most seamen are forced to live on board ship and are exposed, therefore, to hazards even when they are not working, (2) no records of the hours worked on board ship are available; (3) some work is performed beyond the usual workday; and (4) on those ships where seamen do not live on board the vessel, such as certain tugs, two different crews may be employed in 1 day." U.S. Bureau of Labor Statistics, *Workmen's Compensation and the Protection of Seamen*, Bulletin No. 869, pp. 9-10

⁷ U.S. Bureau of Labor Statistics Bulletin No. 772, p. 2.

the records of different plants, departments, operations, sexes, age-groups, etc., to check on the efficiency of his safety program, and to measure the effectiveness of corrective methods used. More generalized frequency rates are useful in comparing the number of accidents in different countries, industries, periods of time, and in many other ways.

Severity Rates. In computing the frequency rate, each injury is given the same weight irrespective of the amount of time lost on account of that injury. An injury resulting in the loss of one day's work counts as much as one that results in the loss of a life.

A separate method has been developed to measure the severity of injuries. The severity rate expresses the number of days lost per 1000 man-hours of exposure, and is stated as:

$$SR = \frac{LD \times 1000}{MH}$$

where SR is the severity rate, LD the number of days lost, MH the number of man-hours of exposure, and 1000 a constant factor. The number 1000 is used rather than 1,000,000 merely as a matter of convenience. Thus a firm that in one year employs 1000 workers for 50 weeks of 40 hours and has 14 injury-accidents that result in the loss of 4200 days would have a severity rate of 4200 times 1000 divided by 2,000,000, or 2.1. This may be roughly expressed as one-half the number of days lost from injuries for every full-time worker, or the number of days lost for every two full-time workers.

The number of days lost can be counted when the injury consists of temporary total disability. The count begins with the day succeeding the one on which the injury occurred and ends with the day preceding the one on which the injured person returns to work, or is declared able to return by a qualified physician. All calendar days are counted, including Sundays and holidays, whether the plant is operating or shut down. It is obvious that the rate overstates the actual amount of working time lost, but it would be impracticable to take days of rest and periods of shut-down into consideration.

In all injury cases other than temporary total disability, estimates of the time lost have to be made. A standardized scale for weighting these other injuries has been established. Death and permanent

total disability are counted as 100 percent of total disability and are weighted at 6000 days lost. The assumption here is that on the average workers who are killed or permanently totally disabled would have lived and worked full time, 300 days per year, for 20 years. The loss of an arm above the elbow or leg above the knee is considered to be 75 percent of total disability and counts as 4500 days. Loss of a finger counts as 300 days and a thumb 600. Weights are thus assigned to other parts of the body. Impairments which do not involve the loss of a member are weighted in the same proportion that the extent of the impairment bears to the total loss of the member involved.

Severity rates are a composite of injury frequency, time charges, and hours of exposure. They are thus "hazard" rates rather than severity rates. They are more significant measures of the hazards of an industry, plant, or occupation than are frequency rates. All other things being equal, an industry that has a severity rate of 10 is twice as hazardous as one having a severity rate of 5. But the rate is not an adequate measure of the severity of individual injuries, since it merely expresses the average number of days of disability experienced per thousand man-hours worked. The following quotation makes this clear: ⁸

Because time charges are geared to exposure hours, industries with large exposure hours may have lower severity rates, even though they experienced a higher proportion of very serious injuries, than industries with smaller exposure hours and proportionately less severe injuries. . . . The explosives industry, for example, had a 1944 severity rate of 1.6, whereas that of the fertilizer industry was 4.7, and of soap and glycerin 2.6. However, in the explosives industry 2.7 percent of the injuries resulted in death or permanent total disability as against 1.1 percent for the fertilizer and glycerin industries. Similarly, 6.2 percent of the explosives industry's injuries resulted in permanent impairment, as against percentages of 3.3 and 5.3 for the other two, respectively.

A more significant measure would be a distribution of injuries by extent of disability and the average time charged for each type of disability. A simple measure of severity would be the average time lost per injury, including standard time charges.

Some Frequency and Severity Rates. Some data on frequency and severity rates in industries other than agriculture are available.

⁸ *Monthly Labor Review*, October 1945, p. 642; also October 1947, p. 445.

Table 54 gives some such rates for the years 1940-1944. Several conclusions may be drawn from the data given, although no claim will be made that the conclusions apply to years not included. Nevertheless, they are suggestive.

The average frequency rate fluctuates yearly, appreciably, and erratically. For the years included, the rate varied from 17.39 in 1941 to 13.76 in 1942, a difference of more than 20 percent. There appears to be no close correlation between the frequency rate and the volume of employment, or exposure, although increasing exposure is supposed to be accompanied by an increasing frequency rate. Employment went up from 1940 to 1941 and so did the frequency, but employment increased again in 1942 and the frequency rate went down. A slight increase in employment in 1943 was accompanied by a substantial increase in the rate.

The average severity rate also fluctuates yearly, appreciably, and erratically. For the years included, the rate varied from a low of 1.19 in 1942 to a high of 1.61 in 1943. The severity rate appears to vary directly with the volume of exposure, but the correlation does not appear to be great. There is a correlation between frequency

TABLE 54. Injury Frequency and Severity Rates, by Major Industry Group, 1940-1944 ⁹

Industry Group	1940		1941		1942		1943		1944	
	F-R	S-R	F-R	S-R	F-R	S-R	F-R	S-R	F-R	S-R
Manufacturing	15 3	1 6	18 1	1 7	19 9	1 5	20 0	1 4	18 4	1 4
Construction	37 0	5 3	47 5	5 7	36 7	3 6	26 1	3 6	27 7	4 2
Communication			2 7	0 2	2 9	0 2	3 1	0 2	3 3	0 1
Transportation	26 3	1 9	26 8	2 4	20 9	2 9	27 7	2 5	33 2	3 5
Heat, light, and power	.	.	11 6	1 7	10 3	1 7	12 6	2 1	12 9	2 3
Waterworks	.	.	19 9	1 2	10 9	0 2	13 7	0 4	21 3	0 7
Personal services	6 4	0 3	10 2	0 5	9 2	0 6	8 8	0 7	9 4	0 7
Business services	4 1	0 4	6 2	0 3	5 1	0 4	9 5	0 7	8 9	0 5
Educational services	11 4	0 2	16 4	0 3	8 0	0 1	16 8	3 7	10 4	0 8
Trade	12 9	1 0	14 5	1 0	13 7	0 7	13 7	0 8	13 7	0 8

and severity rates, but it does not appear to be of a high degree. The slogan of safety engineers, "take care of the frequency rate and the severity rate will take care of itself," does not appear to have a very solid foundation in fact.

Transportation and construction always have the highest industry frequency and severity rates, because of the extraordinary hazards

⁹ *Monthly Labor Review*, August 1941, pp. 334-339, September 1942, pp. 507-571; U.S. Bureau of Labor Statistics Bulletins Nos. 758, 802, 849.

involved. Manufacturing as a whole and waterworks both have high frequency rates, but their severity rates are low, rarely exceeding 1.5 in manufacturing and usually below 1.0 in waterworks. The services, personal, business, and educational, and trade have moderate frequency rates and low severity rates. Only in the communications industry do we find that both the frequency and severity rates are low.

Frequency and the Volume of Employment. There is said to be a direct and fairly close relationship between accident frequency rates and the rate of industrial operations. As the rate of business activity increases, the accident rate is said to increase, and vice versa. This tendency is indicated, although not accurately measured by the data in Table 55. The data given in Table 54 for the years 1940-1944 do not indicate this same tendency.

The relationship between injury-frequency rates and the volume of employment was found in one study made by the U.S. Bureau of Labor Statistics to be very close in 11 of the manufacturing industries examined, close in 6, fairly close in 7, and slight in 3, which were carpets and rugs, flour, feed, and other grain products, and glass. In the manufacture of motor vehicle parts, the relationship was found to be inverse, that is, the injury-frequency rate went down as employment went up, and vice versa.¹⁰

TABLE 55. Indexes of Employment, of Frequency Rate of Work Injuries, and Average Hours Per Worker, in All Manufacturing Industries, 1936-1941 ¹¹

(Average, 1936-1941=100)

Item	1936	1937	1938	1939	1940	1941
Employment	94 4	103 5	85 5	92.3	102 5	121 8
Average weekly hours per worker	104 7	100 1	91 6	98 0	100 2	105.3
Frequency rate	107 3	107 3	91 1	92 9	92 3	109 1

Frequency and Size of Plant. Small plants generally have worse accident records than medium or large plants. A study made in 1941 by the U. S. Bureau of Labor Statistics of 6762 establishments in 19 manufacturing industries employing 1,315,000 workers and reporting

¹⁰ U. S. Bureau of Labor Statistics Bulletin No. 951, pp 953-954.

¹¹ *Monthly Labor Review*, May 1943, p 951.

72,000 disabling injuries during a period of one year, provides some data on the subject.¹²

It was found that in 10 of the 16 industries, small plants had higher injury-frequency rates than either medium or large plants. In two industries, however, cut stone and stone products and planing mills, the large plants had the higher rates. In four, brick, tile and terra cotta, canning and preserving, fertilizer, and sawmills, the medium size plants had the higher rates. A more recent survey made by the Bureau showed that about 70 percent of all industrial accidents occur in small plants.

State factory inspectors are keenly aware of this deficiency on the part of small plants. They find that small employers have little information or experience in safety work, there is little specialization on operations, employees use work methods they think up or have seen others use, and neither employers nor employees are safety conscious. "Feeble efforts on the part of employers, employees, and interested groups of individuals of these small concerns have only scratched the surface, but they have provided some small measures of safety which have been indirectly beneficial."¹³

Insurance companies assuming these small risks have met the problem and have exerted themselves to secure a reasonable measure of compliance with their safety recommendations. But "in the years gone by many of the hazards have been overlooked because of the variations in the premiums and competition among the various insurance groups. Their laxity has been apparent, both from the standpoint of enforcement and from the standpoint of compliance." As a result, financial losses have been experienced, although fortunately the law of averages "kept their percentage to the minimum. We have had insurance companies begging for cooperation from state agencies in carrying the risk of many small employers."¹⁴

Women and Accidents. Available data indicate that women work as safely or more safely than men. Safety experts seem generally to have that opinion. A special study made by the U.S. Bureau of Labor Statistics showed that in a group of five paper mills the composite frequency rate for men in 1943 was 15.6 as against 11.3

¹² Max D. Kossoris, "Accident Hazards by Size of Plant," *Monthly Labor Review*, April 1943, pp. 647-651.

¹³ Joseph T. Faust, in the U.S. Bureau of Labor Statistics Bulletin No. 678, p. 63.

¹⁴ *Ibid.*, p. 64.

for women, and that during the first 6 months of 1944 the rates were 15.9 for men and 12.6 for women. In rubber plants, the frequency rate for men was 14.9 and for women 6.4. No data on the severity rates were published in that study.¹⁵

It should be borne in mind that in general women are in the less hazardous industries and in the least dangerous jobs in hazardous industries. Frequency and severity rates would therefore tend to be lower for women than for men. In trade, for example, the hazardous work of getting stock to the shelves is done by men, while women do much of the selling.

During the Second World War, women in large numbers were employed to do work similar to that done by men. A special study of 3791 disabling injuries occurring over a period of one year in selected departments of nine shipyards was made. Women doing work requiring considerable movement, climbing, or working in awkward positions experienced more accidents than men doing the same types of work. In all nine shipyards, women were employed as welders and burners, in three yards in assembly operations, and in two yards in electrical and sheetmetal work. It was found that:¹⁶

In nearly every department studied, women experienced relatively more disabling injuries than men. In welding and burning operations, the injury-frequency rate for women was 64.6, against 41.3 for men. In assembly work, the composite rate for three yards was 74.6 for women and 58.5 for men. In sheet-metal work, the comparable rates for women and men were 92.1 and 50.3. Women made the best showing in electrical shops, with a rate of 39.1 as against a rate of 35.6 for men. The reason for this better experience appears to be that work in the electrical shop is of a repetitive and routine nature and lends itself more easily to close supervision.

However, women generally follow safety instructions more closely than men, are more afraid of getting hurt, are more concerned about their appearance, are less prone to "show off" or to participate in "horseplay," report more faithfully to first-aid centers when injured, take more time off to recover when injured, and are anxious to prove themselves as good as men.¹⁷

¹⁵ "Industrial Injuries to Women Workers," *Monthly Labor Review*, February 1945, pp. 310-315.

¹⁶ *Monthly Labor Review*, March 1945, p. 551.

¹⁷ *Ibid.*, February 1945, pp. 311-315.

Accident Proneness. It is well known that some persons are more prone to suffer injuries than others. The test of proneness is not simply the number of accidents experienced by a person in a given period of time, for some occupations are more hazardous than others. An accident-prone person is one who in any given period of time experiences appreciably more injuries than others doing the same kind of work under the same general conditions. It is not possible to give a satisfactory overall picture of accident proneness, but the following figures for a medium-sized packing plant are suggestive.

A careful count of all injuries occurring to employees over a period of 12 months was kept.¹⁸ The 330 employees who had been employed throughout the 12-month period had a total of 1274 injury-accidents, or an average of about 4 per individual and 5.7 per injured individual. Of the 330 employees, 106, or slightly more than 32 percent, were not injured at all during the year. Of those injured, 32, or nearly 14.3 percent, had only one injury, and 28, or about 12.5 percent, had two. A total of 82, or 36.6 percent, had from 3 to 5 injuries, and 53, or 23.7 percent, had from 6 to 10. Twenty-nine, or 13 percent of those injured, had more than 10 injuries, and of these, one had 31.

ACCIDENTS AND SAFETY

The tremendous number of occupational injuries experienced in this country has led to studies of their causes and of methods for preventing them. Considerable progress has been made along both lines, but much still remains to be done.

Factors and Causes. Students of accident prevention have developed a framework for analyzing accidents with a view to more effective preventive efforts. The main outline of that framework throws considerable light on the problem for the general reader.¹⁹ A part of the framework will be given here.

The basic factors in accidents are said to consist of: (1) unsafe working conditions, and (2) unsafe acts of persons. Unsafe working conditions may in turn be subdivided into: (a) the agency, such as

¹⁸ U S Bureau of Labor Statistics Bulletin No 885, pp 22-23, 1943

¹⁹ See H W Heinrich, *Industrial Accident Prevention*, McGraw-Hill Book Company, Inc., 1941.

a lathe, planer, or punch press; (b) the agency part, as for example gears; and (c) unsafe mechanical or physical conditions, such as an unguarded emery wheel or a slippery floor. Unsafe acts of persons are of many different kinds. They are generally classified as: operating without authority or at unsafe speeds, failure to secure or warn, making safety devices inoperative, using unsafe equipment, using hands instead of equipment, or using equipment unsafely, unsafe loading, placing, mixing, combining, etc., working on moving or dangerous equipment, distracting, teasing, abusing, startling, etc., and failure to use safe attire or personal protective devices.

The proximate cause of an accident must be either an unsafe working condition, an unsafe personal act, or a combination of the two. However, several specific types of accidents have been distinguished. The most important are: struck by, caught in, on, or between, and falls on the same or different levels. Others are: slips or overexertion, contact with temperature extremes, inhalation, absorption, injection, and contact with electric currents.

The relative importance of unsafe working conditions and unsafe acts of persons as basic accident factors varies from industry to industry, and from time to time. A study of the brewing industry, which is not suggested as being typical, resulted in the conclusion that over 43 percent of the accidents resulted from unsafe working conditions, and that 40 percent of those were associated with defective materials and equipment and 15 percent resulted from lack of adequate safeguards on machinery.²⁰ Where unsafe acts of persons were involved, more than 50 percent of the accidents resulted because the injured worker had unnecessarily placed himself in an unsafe position or posture, and five of the six fatal accidents reported that year resulted from unsafe acts. The use of unsafe mechanical equipment or the use of equipment unsafely accounted for relatively few of the accidents.

The Safety Movement. In its early years, the safety movement had a strong emotional and a weak economic basis. The National Safety Council once defined accident as "a word used to excuse neglect; to hide our weakness; ease our conscience and cover our failure."²¹ That was strong emotional language, full of heat and devoid of light. But it was found that the emotional appeal and the

²⁰ *Monthly Labor Review*, July 1946, pp. 73, 76.

²¹ U.S. Bureau of Labor Statistics Bulletin No. 667, p. 135.

tactics of belaboring and ridiculing those concerned did not influence as many people as should have been reached, and what is more important did not offer employers any technical assistance in reducing accidents. The economic appeal was then given more stress, with better results. The most significant aspect of the safety movement, particularly in industry, has been the development of techniques for accident prevention, and the education of employers and workers in their use.

Careful analysis of detailed accident reports from many different types of plants and over an extended period of time has led safety engineers to the conclusion that it is within the realm of practical possibility to reduce the number of accidents by at least 50 percent and to do it economically.²²

Attacks have been made on all manner of unsafe working conditions, such as devising less hazardous machinery and processes, constructing safety devices for machinery and equipment, providing protective attire and devices for individual workers, and eliminating dangerous dusts and gases. Workers are informed concerning their many unsafe acts, and instructed in safe attitudes, positions, and practices.

Many successful safety campaigns have been conducted, notably in the iron and steel industry. But the work has to be done over and over again and constant vigilance by professionally trained safety engineers is required to keep rates down.

One important source of weakness in the safety movement has been, and still is, ineffective factory inspection by state labor departments.²³ State factory inspectors are generally inadequately trained when appointed, and continuous and systematic training and instruction throughout the year is still found in only a few states. An adequate and well-trained state factory inspection staff could, if it pursued its task diligently, do much to reduce accidents in the smaller plants.

Furthermore, too often safety does not stay "sold." Under pressure, many employers will react favorably, but when the pressure for safety is off, they become backsliders. During the war, considerable

²² *Accident-Record Manual for Industrial Plants*, U S Bureau of Labor Statistics Bulletin No 772, 1944

²³ U.S. Bureau of Labor Statistics, *Proceedings of the Twenty-Sixth Convention of the International Association of Government Labor Officials*, September 1940, Bulletin No 690, especially pp. 129-133

pressure was exerted, with some success. But the U.S. Department of Labor reported in 1946 that "there is evidence . . . that many establishments are giving up entirely or are curtailing the safety work initiated during the war."²⁴

A SUMMARY VIEW OF THE INJURED

It is difficult to visualize the magnitude of any major problem. Statistics do help. But injured men and women are not really numbers in columns, totals in tables. They are people in graves, on beds, on crutches, or in wheel chairs. They are scattered far and wide over the vast expanse of a large country, and no one sees many of them. Perhaps a better picture of what the accident figures mean can be conveyed by this graphic statement:²⁵

If we could visualize the casualty list from accidents in modern industry we might see this shocking picture: 34 miles of corpses, lying end to end, of those killed in industry, a pile of 12,940 arms and legs capped by 17,000 lost eyes—a mountain of human flesh sacrificed to the machine. In addition we would see an army of some 80,000 permanently disabled workers who could never be as useful again. If we could survey all American industry while it was operating, we would observe 10,000 more being injured for every single working day.

In order the better to visualize the number injured annually in work accidents, let us march them before us in a solid column of four at quick time as though they were soldiers, passing our reviewing stand at the rate of 1000 every 35 minutes. It would require slightly more than 130 hours for them to pass in review. The review could go on without interruption for five days and six nights, or for 8 hours per day for 16 days. The dead would pass in 56 minutes, the total permanent disabilities in 6 minutes, the permanent partial disabilities in 5½ hours, and the temporary total disabilities in 123½ hours. Every year we could hold such a review of the occupational casualties of that year.

OCCUPATIONAL DISEASES

An accidental injury is one that generally results from sudden and unexpected violence and causes a break in or fracture of some part

²⁴ Bulletin No. 885, pp 22-23, 1943.

²⁵ Emanuel Stein, Jerome Davis, and others, *Labor Problems in America*, Farrar and Rinehart, Inc., 1940, p. 50.

of the body, as when a hand is cut off by a buzz saw. Most of the casualty list of industry is made up of persons who have been injured in accidents. But many workers are afflicted with diseases, which unlike accidents are usually unknowingly contracted, difficult to detect in their beginning stages, and generally, although not always, take considerable time to run their courses.

Diseases which are contracted in connection with one's work are called occupational diseases. In many, perhaps most, cases the same disease may be contracted off the job and in some activity not related to one's work. Tuberculosis and anthrax may be offered as examples. But most occupational diseases are not common among the nonworking population, or the incidence of the disease is markedly greater among workers.

Known in Ancient Times. Occupational diseases are not a modern phenomenon, for they have long been known to exist. Pliny wrote in ancient times of the "diseases of slaves," and Georgius Agricola described the diseases of medieval miners. The first treatise on the subject was written by Bernardino Ramazzini in 1750.²⁶ In the past fifty years, however, they have come to assume a new and greater importance. New materials and processes have brought new diseases, some of them spectacular in character. There has been a great increase in the use of poisonous materials in industry and relatively larger numbers of workers are exposed to the dangers involved. Women and children have been exposed to the dangers in ever larger numbers, absolutely and probably relatively. Poisonous materials have generally been put into use before adequate safety precautions against their noxious effects could, or would, be designed and applied.

Types and Causes. There are many different types of occupational diseases, and no standard classification has as yet been established. Some, perhaps most, of the diseases result from the use of poisonous materials such as lead, benzene, methyl alcohol, mercury, carbon disulphide, nitric and chromic acid, radium, and vanadium. Well known among these occupational diseases are lead poisoning, which is perhaps the best known, "hatter's shakes" from mercury, zinc "shakes," and brass "chills." Other diseases result from germs, such as tuberculosis, anthrax, and hookworm. Extreme temperature

²⁶ Rosamund Goldberg, *Occupational Diseases*, Columbia University Press, 1931.

changes lead to respiratory diseases, rheumatism and lumbago, air pressure to the "bends" among "sand hogs," and artificial humidity when combined with high temperatures to tuberculosis. Carbon monoxide, perhaps the oldest industrial poison, since it dates from the use of fire, and the one that has killed the most people, has taken a terrific toll. Improper lighting may lead to spasmodic eye movements such as miners' nystagmus or to cataracts and eye infections. Dust or fumes containing mechanical irritants may lead to such diseases as asbestosis, silicosis, and cancer or ulcer of the skin, liver, or eye in the case of pitch, tar, and bitumen. The constant use of certain parts of the body sometimes leads to neuritis, as in the case of telegraphers, stonecutters, and pneumatic drillers.

Compensation. In the earlier days it was rarely possible to collect damages for such an injury, not only because of the rigorous common-law doctrines prevailing, but also because the responsibility for occupational diseases could not so easily be fixed on industry as could that for accidents. And where the responsibility could be fixed on an industry, it was not easy to fix it on any particular employer, or to allocate the responsibility justly among different employers, especially in this country because of the marked mobility of American workers. As a result, occupational diseases have not until recently received the careful study they deserve and we have been slow to take necessary remedial measures. Writing in 1916, Dr. I. M. Rubinow could say that "the study of this problem in this country is still in its infancy."²⁷

None of the first workmen's compensation laws specifically included occupational diseases among the injuries covered, again because of the difficulty of fixing responsibility and justly allocating costs. However, the Massachusetts law was from the beginning construed to include occupational diseases under the general term "injuries"; the Wisconsin law was held to cover occupational diseases which occurred as the result of a specific exposure; and in some states the courts approved awards in cases where an occupational disease contributed to an accidental injury.

Considerable progress has now been made in including occupational diseases in compensation acts, as will be pointed out later. Legislation has also been enacted to reduce the hazards involved

²⁷ *Social Insurance*, Henry Holt & Company, Inc., rev. ed., 1916, p. 211

in the use of dangerous materials and to safeguard working conditions. The beginnings have developed of a movement to provide safety inspectors who are technically trained in chemistry and bacteriology and whose function it is to detect conditions leading to occupational diseases and to correct those conditions. Responsibility is being placed in state public health and hygiene departments rather than in labor departments.

THE COST OF INJURIES

No one is disposed to deny that the cost of industrial accidents is great, even excessively so. Yet no one knows how great the cost is, and there is a tendency to exaggerate its extent. Some of the elements involved are difficult to define, and it is practically impossible to compute the extent to which these elements cause money losses.

Many separate elements enter into the total cost, which may be classified as direct and indirect. The direct costs are made up of such items as the amount of compensation paid to injured workers, the medical and hospital expenses incurred, wages paid to injured workers by some employers, administrative expenses borne by employers and government which are attributable to accidents, and the legal expenses incurred in connection with accidents by employers, workers, and governmental bodies.

The indirect costs consist of such items as the time lost by injured workers, by their fellow workers who leave their tasks to help, look on, or merely gossip at the time of the injury, and by supervisors who have to handle the details attendant upon an accident, the expense involved in first-aid attendants, and the damage and destruction to machinery, tools, materials, and other property.

It is possible to estimate fairly accurately the cost of compensation and income loss suffered through lost time, the damage to machinery and other similar costs. But most of the indirect, or hidden, costs defy even reasonable estimate. Commenting on the problem, one insurance company executive has said: ²⁸

It seems to me that there is a lot of conviction in the information on probable losses. I hear about hidden losses, indirect losses, but the figures

²⁸ W. F. Lund, "What's Wrong With Safety Engineers?", *Safety Engineering*, August 1947, p. 26.

that the Engineer presents are always the amount of money paid because of claims. Why doesn't he dig up more facts about the other costs associated with any accident? If there is a loss of time, damage to equipment, increased maintenance cost, interference with production, why isn't there more evidence in the statistics that he maintains?

A serious and widely circulated study by Mr. H. W. Heinrich, of the Travelers Insurance Company, an outstanding student of the problem, made in 1931 gives estimates of the total costs of industrial injuries for that time. It is reproduced in Table 56.

TABLE 56. Estimated Annual Direct, Hidden, and Total Cost of Industrial Accidents in the United States ²⁹

Nature of Accident	(In Millions)		
	Direct	Hidden	Total
3,000,000 compensable injuries at \$246 each, including 25,000 fatalities	\$738	\$2952	\$3690
87,000,000 minor injuries at \$2 each	174	696	870
900,000,000 no-injury accidents at \$0.50 each	...	450	450
Total annual cost	912	4098	5010

The total annual cost was estimated at \$5 billion, nearly \$1 billion direct and the remainder hidden or indirect. Approximately 75 percent of the direct cost was allocated to compensable injuries. The 87 million minor, or no-lost-time injuries were estimated by applying a ratio of 29 minor to 1 serious injury, a figure arrived at in a careful study in the manufacturing industry, and the 900 million no-injury accidents were estimated by applying a generally accepted ratio of 300 to 1, and roughly \$1 billion of the total cost was allocated to them. The direct compensable cost of \$246 per injury was estimated by the U S. Department of Labor, and the hidden or indirect cost of 4 times that much was based on a study of a random sample of 10,000 cases taken from the files of the Travelers Insurance Company.

Despite the fact that this widely accepted study was made by a careful and competent student and based on the best data available, the total cost appears to be greatly, if not grossly, exaggerated. The

²⁹ H W Heinrich, *Proceedings of the Seventeenth Annual Meeting of the International Association of Industrial Accident Boards and Commissions*, U.S. Bureau of Labor Statistics Bulletin No. 536, pp 171-179, 1931.

estimated costs per injury are probably reasonably accurate. No one could seriously dispute a direct cost of \$2 per minor injury and \$0.50 per no-injury accident, although one might question whether the same ratio of direct to indirect cost applies. It is the number of injuries used in the computations that appears to be exaggerated.

Assuming for 1929, the peak year before the depression, a working force of 45 million, employed 50 hours per week for 52 weeks, we get an exposure of 117.0 billion hours. In other words, if every person then classed as "gainfully occupied" was employed full time, the exposure would have been 117.0 billion hours. However, allowance must be made for about 1.5 million unemployed, and for short time. The latter may conservatively be estimated at 20 percent of the total, averaging half time. Actual exposure was probably nearer 110.0 billion hours, and was probably less than that. The injury frequency rate may be estimated at 20 per million hours of exposure. The total number of lost-time injuries would, under these assumptions, have been 2,200,000. Accepting the standard ratios of 29 no-lost-time injuries to 1 lost time, and indirect costs four times as much as the direct, the Heinrich estimate would appear to be at least 30 percent too high.

The U.S. Department of Labor estimated that for 1945, lost-time injury accidents cost 218 million man-days, including the standard time charges for death and permanent disability. There were 2 million lost-time injuries that year.³⁰ Assuming that each of these involved a direct cost of \$400 instead of \$246, and indirect costs 4 times as much, the total cost of this item would be \$4 billion, which is only \$310 million more than the Heinrich estimate for some 15 years before. The labor force was at least 40 percent greater in 1945 than in 1929, and weekly hours worked about 20 percent less. Employment was as full as in 1929 and more mechanized. One would expect a greater difference in cost, if the early estimates are correct.

The National Safety Council estimated the direct and hidden cost of lost-time occupational injuries in 1946 at \$2.4 billion. Minor injury and no-injury accident costs are in addition, but no estimate of them was given.³¹

³⁰ *Monthly Labor Review*, March 1946, p. 411

³¹ W. C. James, "Looking Back on 1946," *National Safety News*, August 1947, p. 56.

COMPENSATION FOR OCCUPATIONAL INJURIES

The cost of occupational injuries must be borne by someone. Too often it has been borne mostly or entirely by the injured worker and his dependents. Generous employers and philanthropists have in the past done something to alleviate the suffering and distress of those injured, but generosity cannot be expected to do much, certainly not enough. There must be legal recourse for damages suffered.

A system of common law grew up in Anglo-Saxon countries which was designed in part to do justice as between the injured person and his employer. Perhaps it was adequate for a simple economy, although one may well doubt it. Legislative modifications of the common law attempted to make adjustments called for by changes in business organization and productive techniques. This is called employers' liability legislation. But it also proved to be inadequate. An entirely new system, called workmen's compensation, was then devised. All three still exist.

The following chapters will deal with the problems of compensating occupational injuries according to the various systems.

CHAPTER FIFTEEN

THE COMMON LAW AND EMPLOYERS' LIABILITY LAW

EVER since the workingman achieved personal freedom, the compensability of injuries suffered in the employment of others has been determined in accordance with some legal pattern, although no pattern of law has ever fully compensated him for his losses. In this chapter, we shall trace in broad outline the pattern as it had developed before modern workmen's compensation legislation was enacted.

THE COMMON LAW

The legal relationships between employer and employee regarding compensation for injuries before our present system of workmen's compensation was established were determined by the common-law doctrines of reasonable care, assumption of risk, contributory negligence, and coservice. Another common-law rule limiting recovery was the general maxim that a right to damages for personal injury died with the person injured. That rule was abolished by "wrongful death statutes" which gave personal representatives of fatally injured persons any right that the deceased might have had to sue for damages, and by supplemental acts conferring the same right, under special circumstances, to other than personal representatives.

The common law is still the basis for determining liability in a relatively small segment of the economy. That is generally true in agriculture and domestic service. Employers' liability laws, which will be described later in this chapter, have modified the common law to an appreciable extent, especially in mining and railroading. The common law as modified by employers' liability and safety laws, is applicable to injuries exempt from the coverage of work-

men's compensation legislation, of which there are still substantial numbers. Workmen's compensation will be described in the following chapter.

Duties of the Employer. According to the doctrine of reasonable care, it is the master's duty to exercise reasonable care and diligence in providing and maintaining a safe place in which to work, safe machinery, tools and materials, inspection and repairs, suitable, competent, and sufficient fellow workmen, to establish and enforce rules and regulations, and to warn of hidden or unusual dangers known to him but not to the servant.

It should be noted that by reasonable care and diligence is meant common or usual or average care and diligence, and the phrase does not imply any model or superior standard of training or conduct or equipment. A workshop might be quite unsafe, but if it is no more so than most others of its kind, the master is not thereby guilty of negligence. Machinery need not have safeguards unless safeguards are common. And it is presumed that anyone who applies for work is competent, unless the master knows or could reasonably be expected to know that the applicant is not competent. The master's negligence is never presumed; it must be proved by the plaintiff.

For an injury resulting from failure or neglect to perform any part of this duty, the master is liable for damages, whether the failure or neglect is his own or that of one to whom the performance of this duty has been delegated. The liability is for the full amount of damage suffered, in contrast to the limited liability imposed by modern workmen's compensation laws

The Employer's Defenses. However, negligence on the employer's part does not automatically and absolutely assure the injured worker of damages, for the employer has certain defenses which he can plead, even though he was himself negligent.

Assumption of Risk The servant assumes all the ordinary risks and hazards inherent in, incident to, or attendant upon his employment; that is, all those risks and hazards of his employment which are purely fortuitous or open to common observation and are as fully known to him as they are to his master, or which he is, or may reasonably be expected to be, capable of knowing and measuring.¹

¹ "The maxim *volenti non fit injuria* is a terse expression of the individualistic tendency of the common law, which, proceeding from the people and asserting their liberties, naturally regards the freedom of individual actions as

Although it is the employer's duty to furnish a reasonably safe workplace, machinery, tools, and materials, yet if any of these are deficient or defective and the employee knows or should know of the deficiency or defect, and appreciates or should appreciate the consequent danger, but nevertheless continues in the employment without any promise on the part of his employer that the situation will be remedied, or continues for more than a reasonable time with that promise, he is deemed as a matter of law to have assumed the risk of injury from such deficiency or defect. In such cases, the employer is not liable for any negligence of which he himself may have been guilty. Extraordinary risks are assumed only if they are known to and appreciated by the servant.

A good, although somewhat extreme, example of how badly the rule works in some cases comes from New York. A girl worked for a candy company for some six months in the latter part of 1924, in a "damp, unsanitary, unventilated cellar," where she contracted tuberculosis. Suing for damages, she was awarded a verdict of \$2000 by a trial court, which award was reversed by a higher court. The judge in his opinion said.²

The plaintiff was fully aware of the conditions under which she worked, and continued in the employment from June to December in spite of such knowledge. It is from her testimony that we learn that the walls of the cellar were wet to the touch, that a cesspool backed up liquids which wet the floor, that the cellar was devoid of windows to light or air it; that dead rats were left about, that the odors were vile; that no fires were kept in the upstairs room, that the plaintiff worked in a drafty place; that the upstairs room was damp. It is common knowledge that such conditions are deleterious to health. The plaintiff was chargeable with such knowledge. We think that the plaintiff, as a matter of law, assumed the risk attendant upon her remaining in the employment, and that the recovery may not stand.

Two reasons are usually offered in justification of this doctrine: first that, knowing he will be exposed to these risks, the servant in effect contracts to bear them, and that presumably they are reflected in a higher rate of pay; second, that it best promotes the public interest by making injuries less liable to occur to the servant himself

the keystone of the whole structure" Francis H. Bohlen, *Studies in the Law of Torts*, The Bobbs-Merrill Company, 1926, p. 441

² *Wager v. White Star Candy Co.*, 217 N.Y. Supp., 173.

and to third persons.³ The first reason has some truth in it, but the correlation between wages and dangers is not especially high, and varies with changing conditions in the labor markets. There is practically no truth, if indeed there is any at all, in the second reason. It has not been found that modern compensation laws, under which the doctrine of assumed risk is completely discarded, have made workers any less anxious to avoid accidents. Mechem says the real reason is that under the common law a loss must rest where it falls unless it can be attributed to the fault of someone else, and the risks here concerned cannot be attributed to the fault of the master.⁴ That makes some sense, although it may seem rather harsh or unfortunate or primitive sense.

Inexperienced workers and infants who are incapable of understanding and appreciating the risks of their employment do not assume those risks. Nor do seamen and convicts, on the ground that they cannot quit their jobs at will and can be punished for failure to continue at their work.

Contributory Negligence. It is a general rule of the common law, applicable to cases of industrial injuries, that where the plaintiff's negligence in conjunction with that of the defendant contributes to his injury, the plaintiff cannot recover damages. Three degrees of negligence were at one time recognized: slight, ordinary, and gross. Slight negligence on the part of the injured worker did not bar recovery, but ordinary negligence did, even though the worker's negligence was less than that of the employer. Of course, if the employer's negligence was willful or wanton, the injured worker could recover even though he himself was guilty of ordinary negligence.

This "academic" classification of negligence into three degrees came to be ignored, and the general rule now is merely that there is negligence when "the care, diligence or skill demanded by the peculiar circumstances of the particular case" have not been exercised. The difference between this and the previous rule is not easily evident, for the courts must still consider the extent to which both parties exercised due care. A worker who at the express command of the master incurs a danger which is not so inevitable or imminent that an ordinarily prudent man would refuse to incur it and is as a result injured, is not guilty of contributory negligence.

³ *Dow v. Kansas Pac. Rly. Co.*, 8 Kan. 642.

⁴ Floyd R. Mechem, *Mechem on Agency*, Callaghan & Company, 1923, vol. 1, pp. 1210-1211.

Courts have generally held that contributory negligence is an affirmative defense and that it must be pleaded and proved by the employer if it is to serve as a bar to recovery of damages. Where no evidence is introduced on this point it is assumed as a matter of law that there was no contributory negligence.

The doctrine of comparative negligence, which is briefly that where both employer and employee are guilty of negligence contributing to an employee's injury the worker may recover proportionate damages, provided his negligence is less than that of his employer, is part of the common law in only a very few jurisdictions. In some others, it has been introduced into the body of law by statute.

The doctrine of the "last clear chance", which is an exception to the doctrine of contributory negligence, is generally accepted. According to this rule, the test of wrongful conduct is that if just at the very moment when an accident occurred or became inevitable only the master had power to prevent it and neglected to do so, then the legal responsibility is his alone.

The prevailing view in this country is that the master is liable only if he himself was conscious of the servant's danger in time to have been able to avoid the injury by exercising ordinary care and the servant was either unconscious of the danger or if conscious of it then unable by exercising ordinary care to have avoided the injury. A few courts have followed the English version holding the master liable even though he was unconscious of the danger, provided he could have been conscious of it in time to avoid the injury had he exercised reasonable care.

The defenses of assumption of risk and contributory negligence are separate and distinct. The former arises from the dangers inherent in an employment, while the latter arises from neglect on the part of the worker to perform a duty, which neglect aggravates or creates a danger. The former involves a question of contract, the latter a question of conduct. They tend to lose their identity and merge into one, however, where dangers are so obvious, imminent, and appreciated that ordinarily prudent workers refuse to assume them, but where many workers do habitually assume them and ordinarily prudent men under the stress of necessity assume them for extra pay.

Fellow Servant Doctrine. The widest common-law principle governing liability is that every person shall be liable to others only

when he is at fault. The rule of *respondeat superior*, which holds that the master is vicariously liable to a third party for the wrongful conduct of his servants in the furtherance of the master's business—i.e., railways to their passengers for the misconduct of their servants—is an exception to this wider principle. Before 1837, the rule of *respondeat superior* protected servants as well as third parties. But a line of cases beginning in 1837 with the English Case of *Priestly v Fowler* laid down the fellow servant rule.⁵

In *Murray v. South Carolina Railway Company*, an American case decided in 1841, it was held that *respondeat superior* did not apply to cases of this kind, but the decision was divided, did not become well known, and did not settle the question.⁶ The question first received mature consideration in *Farwell v. Boston and Wooster Railway Company*, 1842.⁷ There it was decided that the rule did not apply; and the fellow servant rule that employers are not liable for injuries caused by the negligence of fellow servants was firmly established in American law. However, the reasons given in justification for the rule are not convincing, and decisions as to what constitutes the test of common service are conflicting and irreconcilable.

How the judicial mind viewed the fellow servant doctrine is clearly revealed by a Kansas opinion handed down in 1871.⁸ Dow, a railroad brakeman, was injured while coupling freight cars, allegedly because the conductor carelessly, negligently and unskillfully conducted the train, and he sued for damages. He alleged everything necessary to recover except he did not allege that the railroad was negligent in employing or retaining the conductor whose action caused the injury. An elaborate and able brief was prepared by the defense. The action was apparently instigated by the company for the mere purpose of getting the fellow servant rule established in Kansas. The court specifically noted that more solicitude was entertained concerning the question involved and in the precedent to be established than concerning the case itself, and implied that the defense was responsible even for the presentation of the plaintiff's case.

In an exceedingly brief opinion, considering the importance of the question involved, the Court held for the company. "It is prob-

⁵ 3 M & W 1, 1837.

⁶ 1 McMull, L S Car. 385, 36 Am. Dig. 268, 1841.

⁷ 4 Metc 49, 38 Am. Dec. 339

⁸ *Dow v Kansas Pacific Rly. Co.*, 8 Kan. 642, following the Farwell case.

able," said the Court, "that both authority and reason are with the defendant." Why so? Because it is the "policy of the law to make it to the interest of every servant or agent of the railroad company to see that every other servant or agent of the company is competent and trustworthy." Workers are in the best position to know who is incompetent and careless, and either they should inform the company "of every act of any other employee showing a want of skill, care or competency," or they should quit. If an employee is willing to work with an incompetent or untrustworthy fellow worker without informing the company, "let him bear the consequences." And if he is willing thus to endanger the lives of other human beings, "he deserves punishment." This reasoning showed but little understanding on the Court's part of modern industry and of the position occupied in it by the worker.

If an injury to a worker results from the combined negligence of the employer and of a fellow servant, the employer is liable unless his negligence was remote, but he is not liable if the fellow servant's negligence would have caused the injury even had the employer not been negligent.

For the negligence of a mere fellow servant, the master is liable only if he employs the servant without due inquiry as to his fitness; or employs him with notice of unfitness, or, having notice of unfitness, continues him in his service, or where the servant's unfitness is so gross and notorious that for the master not to know it constitutes negligence. In short, there is almost no liability whatsoever.

Superior Servant Rule. Because in modern industry there are so many grades of labor, it was inevitable that in applying the fellow servant doctrine it would frequently be difficult to determine who are fellow servants. The Superior Servant rule was developed by some courts as a solution of these difficulties, although in most states where it prevails the rule was introduced by statutory enactment.

Two theories underlie the cases involving the rule. The first is that the doctrine of common employment is sometimes not applicable simply because the negligent servant was of a higher grade than the injured servant, irrespective of the nature of the negligence involved, the second is that the doctrine does not apply when the negligent employee, irrespective of his actual rank, was at the time performing some task which it was the master's absolute duty to perform with reasonable care. In the latter case, the negligence of a vice-

principal in performing a task which is not a part of the employer's duty to perform is the negligence of a fellow servant

Thus under the first rule a park superintendent whose negligent driving of a team or a truck caused injury to a worker would supply that worker with a right of recovery against the city, because the superintendent belongs to the managerial class of employees. Under the second rule there would be no right of recovery, for although the superintendent belongs to the managerial group, the task of driving a team or truck is not a managerial function and a superintendent who is performing that task is at the time a simple workman, a fellow servant along with the others. The second rule, which is a functional one, seems to be the more realistic and on the whole the more just, or the less unjust, of the two.

Thus under the common law, three elements are essential to the existence of actionable negligence on the part of the employer: (1) a duty on the employer's part, expressed in the doctrine of reasonable care, to protect the worker from the injury he received, which implies knowledge by the employer of the danger and also power to prevent injury, and which also implies realization on his part that the employee did not appreciate or was not likely to appreciate the danger; (2) a failure of the employer to perform that duty; and (3) an injury caused by that failure. All three elements must be proved by the injured worker, and the absence of any one of them bars recovery. The employer has the three powerful affirmative defenses of assumption of risk, contributory negligence, and coservice.

MODIFICATIONS OF THE COMMON LAW

That framework of law was too narrow and rigid for a complex, expanding, and changing economy. The judiciary found it impossible or impracticable to modify the law adequately, and statutory changes became necessary. The changes introduced by legislatures are known as employers' liability laws. Strangely enough, some states enacted laws which were merely declaratory of the common law prevailing at the time.⁹

⁹ See C. B. Labatt, *Master and Servant*, Lawyers' Co-operative Publishing Company, 1913, vol. v, chap. lxxiii. However, it has been said that such legislation has had the effect of putting whatever rights the worker had under the common law in that class of rights which cannot be contracted away and thus protects employees against coercive contracts of employment, such for example as an agreement to assume certain risks as a condition of employment.

The Fellow Servant Doctrine. Most of the legislation was concerned with the abolition or modification of the fellow servant doctrine, and most of it was applicable only to extra-hazardous occupations such as railroading and mining.

Early Laws. The first legislation modifying the common-law doctrines abolished the fellow servant defense for certain classes of employers, these being nearly always railroad companies. And the very first of these acts was passed by Georgia in 1855 for railroads. It reads: "Railroad companies are common carriers, and liable as such. As such companies necessarily have many employees who cannot possibly control those who should exercise care and diligence in the running of trains, such companies shall be liable to such employees as to passengers for injuries arising from the want of care and diligence."¹⁰

Seven years later, in 1862, Iowa followed suit. By 1900, seven other states had taken similar action.¹¹ Most of the other states subsequently passed similar acts, or had already enacted more restrictive legislation of a type which will be discussed further on. Some states have also abolished the doctrine in the mining industry.¹² Federal legislation in 1908 and later modifications, which will be described below, have in effect abolished the fellow servant doctrine for practically all railroad employment.¹³

The English Employers' Liability Act and American Laws. In 1880, England passed an Employers' Liability Act which influenced American legislation. That act abolished, except for seamen and domestic servants, the fellow servant doctrine where an injury resulted from defective ways, works, machinery, or plant; the negligence of any superintendent or foreman in the exercise of the employer's function, any act or omission by an employee in obedience to the employer's rules or bylaws or instructions, the negligence of any employee in charge of railway signal points, locomotive engine, or train. But in order to recover damages it was necessary to show that the employer or his vice-principal had been guilty of negligence; and if the worker knew of the defect or negligence

¹⁰ Georgia *Laws of 1855*, chap. 155.

¹¹ Wyoming, 1869, Kansas, 1874; Wisconsin, 1875; Minnesota, 1887; Florida and North Carolina, 1897, and Missouri, 1899

¹² Arkansas, Missouri, and Oklahoma

¹³ A Federal act of 1906 was declared unconstitutional by the U S Supreme Court because it was construed to apply also to injuries in purely intrastate commerce *Employers' Liability Cases*, 207 U S. 463.

which resulted in his injury, then he must not have failed, within a reasonable time, to inform the employer. Damages were limited to a maximum of three years' earnings. Notice of injury had to be given within six weeks, action commenced within six months in case of injury, and within 12 months in case of death unless the judge accepted a reasonable excuse

Ten American states had passed laws modeled on the English act by 1911. Alabama led off in 1885 and Massachusetts followed suit in 1887. Colorado and Indiana enacted their laws in 1893, although the Indiana act applied only to corporations. Laws were passed by New York in 1902, Pennsylvania in 1907, Oklahoma in 1907 or 1908, New Jersey and Maine in 1919, and Vermont in 1910.

It should be noted that the doctrine of nondelegability of the employer's duties, which is specifically set forth in the English act and state acts modeled on it, has been developed independently of statutes by most American courts. The specific provision barring recovery in cases where the injured worker knew of the defect or negligence which caused his injury has not in general operated as a new defense for the employer, for it was already available in the assumption of risk doctrine. Time limitations have generally been held to bar recovery under the statutes, but of course injured workers could still sue under the unmodified common law—subject, that is, to the employer's defense of fellow servant. In general the acts have been liberally construed by American courts.

The "Superior" Servant Approach. The fellow servant doctrine has been modified, although not altogether abolished, in many states, and here again mostly for common carriers. These modifications consist of making a distinction between "superior" and "fellow" servants, the former generally being those who perform duties of the employer. The fellow servant defense cannot be pleaded where any injury results from the negligence of a superior servant in the performance of an employer's duty. Most of these laws also establish the "departmental rule," which is that employees in departments or divisions not closely related in actual operations are not fellow servants even though they have a common employer. It should be noted that these two modifications were also developed by many courts quite independently of statutory enactments. The laws also generally provide that knowledge by an employee of any defect or negligence is not a bar to recovery.

The first of these acts was passed by Montana in 1873, while she

was still a territory, and seven years before the English Employers' Liability Act of 1880. It was declared unconstitutional, however, on the ground that it imposed a greater burden upon domestic than upon foreign corporations.¹⁴ The Montana law applies to railroads and mining, and the Oregon law to railroads and construction. The Utah and California laws apply to all employers and thus have the same general effect as the English Employers' Liability Act and of American acts modeled after it.

Colorado has the distinction of being the only American state which by an employers' liability law completely abolished the fellow servant doctrine in all employments, including even agriculture and domestic service. The act was passed in 1901.¹⁵ Pennsylvania in 1938 enacted a law which provides that any injury suffered in the course of employment not covered by workmen's compensation is presumed to be the result of the employer's negligence, and declarations, remarks and utterances made by an injured employee within 12 hours after his injury are admissible as competent evidence. But the act was held invalid by the courts.

Contributory Negligence and Assumption of Risk. The doctrines of contributory negligence and assumption of risk have not been abolished or appreciably modified by employers' liability acts. In a few states, they have been modified by express provisions in safety legislation applicable for the most part to railroads. Some states have defined what risks are assumed, and all others are not assumed unless the injured worker knew of them and failed to inform the employer or his vice-principal within a reasonable period of time. Virginia abolished the assumed risk doctrine altogether for railroads. A good many acts have modified the doctrine of contributory negligence, again largely for railroads, by providing that where the employee's negligence contributes to his injury, damages shall be reduced in proportion to his negligence. This is known as the doctrine of comparative negligence.

The Federal Employers' Liability Act. The great variety in state laws affecting interstate railroads led Congress to establish uniformity by enacting in 1908 the Federal Employers' Liability

¹⁴ *Criswell v. Montana C R Co.*, 1896, 18 Mont 167, 44 Pac 525. By 1910, nine States had such laws. Miss., 1890; Ark., 1893; S. C., 1895; Utah, 1896; Va., in her Constitution, Ore., 1903; Mont., 1903; Calif., 1907; Ohio, 1909

¹⁵ Colo. *Laws of 1901*, chap 67

Act. One major provision of the Act is that where an injury partly results from the carrier's violation of a law enacted for the safety of employees, the defense of contributory negligence is not available. A second major provision is to introduce the doctrine of comparative negligence in cases of injury not involving the carrier's violation of safety acts. The injured employee's own negligence is weighed in determining the amount to be awarded. The third major provision is to abolish the doctrine of assumed risk in all cases where the employer's violation of a safety law was partly responsible for an injury. This Act takes precedence of state acts applicable to railroads where the injury was incurred in connection with interstate commerce.

SAFETY ACTS

Further and important modifications of the common law have been made by courts in their interpretation of safety acts which do not themselves expressly modify those doctrines. The experience of one state will serve as an example of this trend.

Kansas enacted safety legislation for coal mines in which no specific mention is made of the common-law defenses. It is reasonably certain that the legislature was concerned in this legislation with preventing accidents by compelling operators to take specified safety precautions and not with modification of the common-law rules of liability for damages.

As interpreted by the Southern Department of the Kansas Court of Appeals in 1896, the law was held not to abolish the defenses of assumption of risk and contributory negligence.¹⁶ Later, however, it was held that these defenses were abolished. In 1908 the State Supreme Court held that "A miner, in performing the work assigned to him, although bound to exercise due care for his own safety, may assume, in the absence of notice to the contrary, that the owner and the overseer have performed their duty. . . ." ¹⁷ And still later the Supreme Court held that the law "in effect debars the defense of contributory negligence", that it "entirely shifts the risks of the employment from the laborer to the employer. Care for his own safety may impel a miner to watch for treacherous mine roofs, but he is

¹⁶ *Cherokee & P. Coal & Mining Co. v. Britton*, 3 K.A. 292, 45 Pac. 100.

¹⁷ *Barrett v. Dessy*, 78 Kan. 642, Syl. 4.

not legally required to do so. . . ."¹⁸ That the law abolished the defense of assumption of risk was definitely settled in 1913.¹⁹

Kansas also passed a Factory Act, which requires that elevators, hoisting shafts and well holes be secured, that stairways be equipped with handrails and secured at the sides and ends, that certain doors open outward and be kept unlocked, that fire escapes be installed, and that dangerous machinery and appliances be guarded where practicable. A right of action for damages is given in case of injury, and in order to recover damages it is only necessary to prove in the first instance that the accident resulted from or was directly contributed to by the failure to provide the safeguards required by law.²⁰ No specific mention was made of the common-law defenses, and there seems to be no good reason for believing that the Legislature had those defenses in mind.

Just what modifications this act was to make in the common law did not become evident for some time. As early as 1906, three years after it was enacted, the Kansas Supreme Court, following what it considered to be well-settled law, held that the factory act did not exclude the defense of contributory negligence.²¹ At that time the question of assumption of risk was not involved, and so, though mentioned and discussed, was not decided. Some lower courts, however, proceeded on the theory that the common law of assumed risk was in no way affected.²²

In 1907, the question of whether the factory act did or did not abolish assumption of risk was squarely before the State Supreme Court.²³ An exhaustive inquiry was made and great difference of judicial opinion noted. In the leading case holding that such acts do abolish the rule, Judge Taft had argued that since assumption of risk is a term of the employment contract, to allow it where a safety act exists is essentially to waive the benefits of the statute, and that considerations of public policy will not permit such a waiver to be given effect.²⁴ The Kansas Supreme Court had already accepted

¹⁸ *Baisdrenghen v. Ry. Co.*, 91 Kan. 730.

¹⁹ *Cheek v. Ry. Co.*, 89 Kan. 247, 267-268.

²⁰ *Laws of Kansas*, 1903, chap. 356. None of its sections was borrowed from any other state, and this left the Supreme Court free to follow its own ideas in interpreting it.

²¹ *Madison v. Chppmger*, 74 Kan. 700.

²² *Ibid.*, also *Manufacturing Co. v. Daniels*, 72 Kan. 418.

²³ *Manufacturing Co. v. Bloom*, 76 Kan. 127.

²⁴ *Narramore v. Cleveland, C. C. & St. L. Ry. Co.*, 96 Fed. 298.

these general propositions²⁵ But it had never before had occasion to apply them It now held that in Kansas assumption of risk could not be pleaded in cases involving a violation of the factory act.²⁶

Three years after it had interpreted away the assumption of risk defense, the Court again considered the question of contributory negligence. At that time the general rule was that factory acts did not abolish this defense, and in conformity with that rule the defense had previously been held available.²⁷ But judicial opinion throughout the country was undergoing a change, though that change had not as yet proceeded very far.²⁸ The Kansas Court was by that time satisfied of the injustice of the general principle and fell in with the new trend by reversing itself and holding the defense no longer available.²⁹ The Court saw clearly the inadequacy of the common-law doctrines as applied to modern industry. These doctrines, it said, "took their rise at a time when shoes were made at the bench, the weaver had an apprentice or two, and the blacksmith a helper."³⁰ But "common experience everywhere, registered in tables of gruesome statistics, affords fresh demonstrations every day of the inadequacy of the common-law doctrine of reasonable care to provide places and instrumentalities reasonably safe against foreseeable occurrences to meet the situation of men, women and children who must manipulate, and must work in the midst of, the mechanical products of modern inventive genius" And again "The factory act

²⁵ The first in *Railway Co v Bancord*, 66 Kan 51, the second in *K. P. Rly. Co v Reavy*, 29 Kan 170

²⁶ *Manufacturing Co v Bloom*, 76 Kan 127

²⁷ *Madison v Clippinger*, supra

²⁸ Labatt, *op cit.*, vol 5, p 5047

²⁹ *Caspar v Lewin*, 82 Kan 604 Just three months before, the Court had remarked that "The statute . . . fairly admits of a construction which would exclude contributory negligence as a defense as well as assumed risk, but does not do so expressly, and the courts have presumed that such was not the intent and have permitted the common-law defense" *Lewis v. Salt Company*, 82 Kan 163, 167.

³⁰ *Caspar v. Lewin*, pp 631-632 Three years later the Court said "The doctrines of assumption of risk and contributory negligence are not the creatures of any constitution or of any legislative enactment They are court-made rules, invented to meet certain ideals of justice respecting certain social and economic conditions and relations Should the conditions and relations be completely changed, and those ideals wholly fail of realization, the reason for the rules, which is the life of all rules of the common law, would then be wanting, and the court which would go on enforcing them would be a conscious minister of injustice and not of justice" *Buigm v Railway Co*, 90 Kan 194, 198, 1913 Too many courts were for too many years conscious ministers of injustice.

cuts squarely across the common-law doctrine of reasonable prudence and supplies that foresight in reference to the places, structures and appliances which it specifies," and "to submit to a jury the question of prudence and foresight where the law has been ignored (by the employer) would be to reopen a subject which the legislature has closed by a final decision."³¹ It is interesting to note that the original bill for the factory act contained a provision, eliminated by amendment, excusing an employer guilty of gross negligence if he could prove equal negligence on the part of the injured worker.³²

SEAMEN

Seamen are generally employed under conditions that differ considerably from those under which most other people work. For the duration of a voyage, they live on their vessel and movement from that vessel while in port may be restricted. The master exercises absolute authority and dangerous assignments must be carried out by seamen ordered to do so. There is rarely a doctor aboard, and in cases of illness and injury the seaman is given what amounts to little more than first aid and is put ashore at the next port if that becomes necessary.³³

Under Common Law. One of the ancient rights of disabled seamen is the right to maintenance and cure and wages. Any seaman who is injured or becomes ill while in the service of the vessel is entitled to maintenance and medical care until well. If there is a U.S. Marine Hospital available, the seaman is cared for there at no cost to himself or to the shipowner, otherwise the case is at the expense of the shipowner. If the injury or illness is the result of the seaman's willful misconduct, or if his negligence or drunkenness is the major cause, then he is not entitled to maintenance and cure. The seaman is entitled to wages for at least the duration of the voyage for which he signed, even though he is unable to work.

The shipowner is required to use the same "reasonable" care in regard to the protection of his seamen that other employers are required to observe under the common law. An injured seaman has the right to sue for damages, in addition to the right of maintenance

³¹ *Caspar v. Lewin*, 624, 625, 629.

³² Senate Bill No. 4, Session of 1903.

³³ For a fuller description, see U.S. Bureau of Labor Statistics, *Workmen's Compensation and the Protection of Seamen*, Bulletin No. 869, 1946, chap. 1.

and cure and wages. But the injured seaman must, in order to recover, prove that the vessel was not "seaworthy." Under the common law, the shipowner had the defenses of assumption of risk and fellow servant, including superior officers except perhaps the master of the ship, and contributory negligence. In cases of death, recovery was not possible because the common-law rule that action for a personal injury lies with the injured person was not abolished by statute for seamen until relatively recently.

The Merchant Marine Act. Considerable relief has been granted recently by legislation. The same rights and remedies available to railway workers under the Federal Employers' Liability Act of 1908 were given to seamen by the Merchant Marine Act of 1920, known as the "Jones Act." The fellow servant rule was abolished. If the injury results from failure of the employer to obey safety laws, the defense of contributory negligence is not available. If the injured employee is guilty of contributory negligence, and the employer has not violated safety statutes, the doctrine of comparative negligence is applied and damages are scaled down in proportion to the injured employee's negligence. The defense of assumption of risk is not available if the employer has violated safety statutes. In case of death, the right to damages is transferred to the deceased worker's personal representatives. The seaman must still prove that his injury resulted from negligence on the part of his employer, and not merely that the ship itself was "unseaworthy."

But the shipowner's liability is limited. Under old law, in cases of shipwreck or other major calamities, the owner's liability was limited to the amount of his interest in the ship and its cargo after the calamity, if he did not have knowledge of the unseaworthiness of the vessel or of incompetency on the part of any member of the crew. But in 1935, the Congress amended the law to make a shipowner liable to: (a) the value of his interest in the ship and cargo immediately after the wreck, or (b) \$60 per gross ton of the vessel, whichever is the greater. This has substantially increased the owner's liability to injured seamen.

Attempts have been made to secure the enactment of workmen's compensation legislation for seamen, but without success³⁴. The seamen themselves, through their union, at one time attempted to

³⁴ See *ibid* for discussions of these attempts and for recoveries under the older law and the modified law.

secure inclusion under state and Federal laws. During the two World Wars, the seamen were given special protection. They now are not interested in coming under either state laws or Federal laws providing compensation. Shipowners on the other hand favor compensation. To date, no compensation legislation for seamen has been enacted.

DEFECTS OF COMMON AND EMPLOYERS' LIABILITY LAW

It can hardly be disputed that the common law, even as modified by employers' liability acts and by enlightened judicial rulings and interpretations, is almost wholly unsatisfactory as the basis for compensating occupational injuries in a modern economy. The defects have been clearly set forth many times and will be only briefly summarized here.

Defective Logic. First of all, the logic behind that body of law has ceased to have validity in increasingly large segments of our economy, which is characterized by complexity of organization, a high degree of mechanization, great and constantly increasing speed, and injurious chemical and physical processes. The proportion of accidents resulting from hazards inherent in the employment has increased markedly. The New York Employers' Liability Commission found that 87.5 percent of 280 fatal accidents in New York during 1907 and 1908 resulted from "modern" causes, and that most of these were in industries unknown when the various liability rules were made a part of the common law. The Minnesota Commission found that 71.6 percent of 1253 accidents were due to hazards inherent in the employment. A German study of 46,000 accidents resulted in the conclusion that 44.36 percent resulted from the hazards inherent in the employment. A body of law reflecting an economy with relatively few and fairly obvious hazards is logical in such an economy, but it loses its logic as the economy becomes complex. The judiciary, partly because it was blind, but mainly because of the inherent difficulties presented, failed to introduce adequate corrections into that logic, and legislatures moved almost equally slowly and haltingly with their employers' liability laws.

Increasing specialization and interdependence together with the growth of corporations and the increase in the number of persons

employed by individual employers made the fellow servant doctrine a hollow mockery. So illogical did the doctrine become that judges themselves in this country developed the superior servant concept and legislatures abolished or modified the rule, primarily in railroad employment. These modifications were obviously designed to reconstruct the logic of the law, and it must be admitted that they were at least partially successful. Even so, there was but little logic left, and that badly warped. The indictment of the fellow servant doctrine stands despite the fact that it probably accounted for a relatively small percentage of failures to recover damages. The Minnesota Employers' Liability Commission found that only some 5 percent of all occupational injuries were caused by the negligence of fellow servants.

The defense of contributory negligence has been criticized by many quite as severely as the other two, but the logic behind it was certainly not as bad. It is a well-established fact that many accidents do result from the negligence of workers. The Minnesota Employers' Liability Commission found them to constitute 20.8 percent of the total, 15.6 percent being due to what is called "willful" negligence. It is surely not illogical to hold injured workers responsible for their own negligence. The best that can be said against doing so in most cases is that it would profit society more to relieve them of that responsibility, or rather to relieve their dependents of the dire consequences that would otherwise inevitably follow. From this point of view the doctrine of comparative negligence, which is eminently logical, was a step in the right direction, but it did not go far enough.

Inadequate Recoveries. The second major defect is related to recoveries. There were relatively few recoveries under the common law. No comprehensive investigation has ever been made of the amounts recovered by workers or their dependents, for the data are not available. But despite the employer's unlimited liability, recorded experience in a few states shows that the amounts recovered were not large. Nor has any comprehensive study been made of recoveries under the common law as modified by employers' liability acts. The percentage of recoveries was certainly greater after employers' liability acts than before them.

Table 57 combines the recoveries in fatal cases investigated in three states prior to 1911. The percentage of fatal cases in which no compensation was received is high, amounting to almost one-third

of the total. In almost one-half of the cases the amount received did not exceed \$500. Compensation exceeding \$1000 was received in very few cases. In some of these, the figures were well over \$5000.

TABLE 57. Recoveries in 604 Fatal Cases Under Employers' Liability Laws in Three States Prior to 1911 ³⁵

Amount Received	New York	Pennsylvania	Minnesota	Totals	Percent
No compensation	93	89	14	196	32.5
Less than \$100	23	113	7	143	23.7
\$100 to \$500	72	61	13	146	24.1
\$500 to \$1000	16	41	6	63	10.4
Over \$1000	23	19	14	56	9.3

Some idea of the small number of recoveries in cases of nonfatal accidents may be obtained from the following figures for Wisconsin.³⁶ This sample is not adequate to serve as a basis for comprehensive generalizations, but the small percentage of recoveries indicated probably strikes pretty close to what a comprehensive survey would show.

Amount Received	Cases	Percent
Nothing from employer	72	23.5
Amount of doctor bill only	99	32.4
Amount of part of doctor bill only	15	4.9
Something in addition to doctor bill	91	29.7
Something, but not doctor bill	29	9.5

To be sure, the damage awards do not represent all the money received by workers on account of injuries, since some provision was made by private and voluntary agencies for indemnification and relief, although admittedly it was neither comprehensive in scope nor adequate in amount. The most primitive, yet persistent, form of relief was "taking up a collection" for the injured worker or his

³⁵ Two hundred twenty-seven cases by the New York State Liability Commission; 323 cases from Pennsylvania by Crystal Eastman, and 54 cases from Minnesota. Taken from I. M. Rubinow, *Social Insurance*, Henry Holt & Company, Inc., 1913, pp. 93-95.

³⁶ Taken from James H. Boyd, *Workmen's Compensation Insurance*, The Bobbs-Merrill Company, 1912, vol. 1, p. 61.

dependents, which may accurately be described as organized begging. It is a method not completely discarded today. There were some mutual benefit societies that paid modest burial benefits and limited weekly benefits, and the amounts received from these agencies, although not large, were helpful.³⁷

Some trade unions made payments to their members, but neither the total amounts nor the individual plans were impressive except for those of a few railroad brotherhoods. Employers also to some extent helped individually, by making voluntary settlements in death cases and continuing to pay full or reduced wages for limited periods in cases of injury. However, some of those employers were not altogether altruistic, but were interested in avoiding suits for damages. There was also some private insurance, but few workers carried either life or accident policies. More important were the workmen's collective insurance policies taken out by employers, the workers sometimes contributing part of the premiums, which established fixed payments for specified injuries somewhat similar to our modern workmen's compensation, but considerably more restricted in scope and benefits.

On the other hand, workers did not actually receive the entire amounts awarded in damages. Lawyers had to be paid. Where cases were taken by attorneys on a straight fee basis, the cost was generally about 25 percent of the award, but when taken on a contingent fee basis, which was frequently done by ambulance chasing lawyers in doubtful cases, it was from one-third to one-half of the award. The average cost to the worker was probably about 40 percent of his award.

Awards Not Related to Degree of Injury. Not only were there relatively few recoveries, but awards in damage suits and settlements, whether made by juries or by agreement between the injured worker and the employer or insurance company representatives, were too little related to the degree of injury. For example, in one case involving the loss of a leg a jury award was \$15,000, while in another involving a fatal accident it was for only \$500. Railroad workers seem to have been so impressed by a few exceptionally large awards that they have consistently opposed workmen's compensation for their industry until recently. State supreme courts in

³⁷ For some typical relief plans, see the Michigan Employers' Liability Commission's report, 1911, pp. 143-149.

some cases in effect announced that a jury's award of damages would be upheld provided the injured worker would agree to accept a reduced amount specified by the court.

Delay in Settlement. In contested cases, especially in those appealed to higher courts, there were long delays in settlement. Kansas Supreme Court records for the years 1871-1911, which are typical, show that contested cases were seldom disposed of in less than three years after the accident occurred. The average time was four years, for injury as well as for death. In many cases there were delays of five, six, or seven years. Three cases were in the courts for more than nine years, and one for more than ten years. In one Iowa case it required four juries and four appeals to the State Supreme Court, over a period of six years, to settle the case.

Demoralization of Participants. This brings us to another general defect. The common and employers' liability law exerted a demoralizing effect on workers and employers and on certain members of the legal profession and insurance company personnel as well. Many injured workers, especially where the damage done was not extensive, hesitated to sue their employers for fear of losing their jobs as a result. Some employers deliberately took advantage of their injured employees by offering and making small settlements which the workers willingly accepted either because they feared to press for more or because the sums offered appeared large, although considered in relation to the extent of the injury, which was generally better known to the employer than to the workers, they were actually very small. The situation was even more complicated when the employer insured his risks in an insurance company. By assuming the liability of the employer and stepping between him and the worker, the insurer frequently created more and worse antagonism between employer and employee by contesting claims for damages more vigorously and less scrupulously.

This stimulated the development of two contemptible subspecies of human beings, the ambulance chaser and unscrupulous claims agent. A class of unscrupulous lawyers specialized in taking damage suits for workers, generally on a percentage basis. They hunted down cases of injury and persuaded the employee to allow them to sue for damages. Their eagerness to reach the injured worker led others to call them ambulance chasers. Insurance companies had their agents, some of whom stooped to unethical practices in making set-

lements with injured workers and receiving releases from them. They, too, sought to reach the injured worker quickly, so that they might arrive at a favorable settlement.

Neither employers nor workers were happy in this scandalous situation. Employers found it essential to insure their risks. But less than one-half of their premiums ultimately reached the injured workers, about 25 percent going to selling expenses. Even so, it is not clear that insurance company expenses and profits were abnormally high. But it was clear that the system was demoralizing and wasteful.

Lack of Preventive Effects. Another defect, the sixth in our list, was that the system did not sufficiently stimulate the development and application of measures and devices to prevent or appreciably to mitigate industrial accidents. An overwhelming proportion of injuries resulted from assumed risks, contributory negligence, and the negligence of fellow servants, and since the law did not compel employers to compensate for these, except to a limited extent, it did not stimulate preventive measures. With the development of liability insurance in the form of workmen's collective policies, there was more of an incentive, for the premiums were related to the amount of damages employers were required to pay. That there were other important incentives to prevent accidents, economic and humanitarian, is true and important, but not in point here. It is in point, however, to suggest that there are distinct limits to the extent to which accidents can be reduced by compensating for injuries.

Social Inadequacy. Finally it should be noted that also from the social point of view the law was seriously defective. Injured workers who received inadequate compensation, or none at all, frequently became burdens on governmental or private relief agencies or on individuals. They themselves did not bear the entire burden, or even the major portion of it, for they simply did not have the necessary resources. Charity had a demoralizing effect on the worker, even more so perhaps than on his family, and perhaps still more so, although in a different way, on those who provided the charity.

Obviously, the development of a class of ambulance chasers and unscrupulous agents, and the resulting antagonism between workers and their employers, were socially undesirable. A considerable amount of respect and confidence on both sides is necessary, not

only to the efficiency of industry, but to the stability and harmony of social life in the community. And the costs of litigation, including the amounts required to provide courts in which the cases were tried, represent expenditures that were socially objectionable, although necessary under the circumstances.

CHAPTER SIXTEEN

WORKMEN'S COMPENSATION

THE framework of modern industrial technology made the common law of negligence an anachronism. The defects of that body of law were, to be sure, partially eased or mitigated by employers' liability laws, by judicial interpretation of safety legislation, and by the enlightened action of a relatively small number of employers. But the improvements wrought by these factors, while helpful to some extent, were not great enough, and the rapid development of our economy, in scope and techniques, more than counterbalanced those minor improvements.

A new body of law based fundamentally on modern social and economic, rather than on primitive and narrow legal principles, was needed. That body of law needed to be based not on the principle of negligence, but on the principle of injury, and not on the concept of damages, but on that of compensation. In short, the crying need was for a system that would make industry, through employers, liable to compensate injuries without regard to whose fault, if to anybody's fault, the injury was due. Workmen's compensation was the answer, an answer which the leading European industrial nations found many years before it was adopted in the United States.

THE BACKGROUND

Like other social insurance movements, workmen's compensation has a fairly long history. The roots of the movement go back to Europe, as is also true of other social insurance movements. Germany and England were the pioneers which had the greatest influence on us.

Early European Laws. The principle of workmen's compensation seems to have been first adopted on a limited scale in Prussia on November 3, 1838, when railroads were made liable for injuries

to employees as well as to passengers, provided the injury was not caused by the worker's negligence and was not an "act of God."¹ Later a movement for a general compensation law was supported by industrialists, economists, and Socialists. Bismarck, who at one time was opposed, supported the first bill introduced in the Reichstag in March, 1881, largely it is believed to counteract the growing strength of the Socialist Party. A broad compulsory compensation law was enacted in July of 1884, effective October 1885. Bismarck had much to do with its enactment. That act is the parent of all workmen's compensation legislation, although some of its progeny have developed characteristic variations.²

England followed suit in 1897, but with several important differences: in Germany employers were required to insure their risks and employees were required to pay part of the cost, whereas in England employers were merely made liable, the entire cost was placed upon the employer, and administration was left to the courts. Americans were influenced more by the English than by the German act, largely because the German act was designed to fit into a highly centralized totalitarian type of government differing greatly from British-American democracy.

Repercussions in the United States. American interest in European social legislation was slow to develop. This was partly due to inadequate news coverage of European experiments. Adna F. Weber writes that the only news in the American press of the rapid European advances in social insurance between August of 1897 and April of 1898 was about the defeat in Switzerland of proposed compulsory sickness and accident insurance.³ In 1891, John Graham Brooks began a comprehensive study of the German system. The results were published in 1894 by Carroll D. Wright as the *Fourth Special Report of the U.S. Commissioner of Labor*. Although greatly impressed, Mr. Brooks thought that the German experience did not offer an adequate basis for American action and that we could "afford nothing so well as to wait the evidence" of the next ten years. Mr. Wright thought that twenty years of experience would provide an adequate basis for conclusive evaluations. In 1898 the first American general survey of European social insurance was published by

¹ Ralph H. Blanchard, *Liability and Compensation Insurance*, D Appleton & Company, Inc., 1917, p. 83

² *Ibid.*, p. 86

³ *Political Science Quarterly*, vol. 17, 1902, pp 256-283.

Dr. W. F. Willoughby of the U.S. Department of Labor. Dr. Willoughby favored compensation laws, deplored the fact that we were so far behind other nations in this field of legal reform, was depressed by the fact that the very principles involved were not even comprehended, and believed that the first step should be to educate public opinion.⁴ A report by Dr. Adna F. Weber to the New York Bureau of Labor Statistics, published in 1899, surveyed European workmen's compensation legislation and concluded that such legislation was suitable and feasible for America and that should one state assume the lead others would quickly fall in line.⁵

The Social Reform Club of New York City appointed a committee, with Miles M. Dawson as chairman, to study German social insurance and English workmen's compensation. That committee prepared a bill, modeled after the British plan, which was introduced in the New York Senate in 1898 by Senator John Ford Theodore Roosevelt, governor of New York, favored the bill, but trade unionists, interested in more stringent employers' liability laws, and others who believed that the "time was not yet ripe," successfully opposed its enactment. The attempt did, however, formally launch the American movement and made some contribution to the education of Americans on this subject.⁶

Early American Laws. Maryland is generally credited with the first American workmen's compensation act. In 1902 it provided that in mining, quarrying, steam and street railways, and in the excavation and construction of sewers and other physical structures for municipalities, dependents of those killed in accidents would be paid \$1000 without proof of negligence. The insurance commissioner was authorized to extend the act to any industry he deemed it prudent to include, and to exempt any company making better payments than those provided by the law. Employers could escape liability for damages by paying the state insurance commissioner premiums based on the number of their employees, and they could deduct half of the amount from their employees' wages. After slightly less than two years, the act was declared unconstitutional by a Baltimore

⁴ W. F. Willoughby, *Workmen's Insurance*, Thomas Y. Crowell & Company, 1898, pp 328-329

⁵ New York Bureau of Labor Statistics, *Seventeenth Annual Report*, 1899.

⁶ J E Rhodes, *Workmen's Compensation*, The Macmillan Company, 1917, p. 89; C. R. Henderson, *American Economic Association Quarterly*, April 1908.

court, on the ground that it gave the insurance commissioner judicial powers and also deprived individuals of the right to trial by jury.⁷ The decision was not appealed.

The Massachusetts legislature in 1903 provided a committee headed by Dr. Carroll D. Wright, which after investigation prepared and recommended a bill based on the British act of 1897, but the legislature rejected it on the ground that the state's industries would be put to a competitive disadvantage with those of other states.⁸ A second committee, appointed in 1907, thought a compulsory act would be "premature" but recommended an act authorizing employers voluntarily to set up plans which, if approved by the State Board of Conciliation and Arbitration, would be substitutes for the common and employers' liability laws. The 1908 legislature enacted such a law, but it remained practically a dead letter.⁹

An Illinois commission, appointed in May, 1905, largely through the influence of Professor Charles R. Henderson, recommended a voluntary, mutual insurance, jointly-contributory plan with a low scale of benefits, but it was almost unanimously opposed by organized labor, and it was not enacted.¹⁰

In 1908, President Theodore Roosevelt succeeded in bringing about the enactment of a compensation law for certain categories of Federal employees. Samuel Gompers, president of the American Federation of Labor, claimed that the bill was passed "wholly and solely through the activities and at the expense" of his organization.¹¹ The act covered civilian employment in government manufacturing establishments, arsenals, navy yards, river and harbor fortification construction, hazardous construction work for the Isthmian Canal Commission, and in the reclamation or management of arid lands. Injured workers, after a fifteen-day waiting period, or

⁷ Thomas S. Adams and Helen Sumner, *Labor Problems*, The Macmillan Company, 1927, 1905, p. 488, George E. Barnett, "The End of the Maryland Workmen's Compensation Act," *Quarterly Journal of Economics*, February, 1905, p. 321. A purely optional law, which remained a "dead letter," was enacted in 1910.

⁸ I. M. Rubinow, *Social Insurance*, Henry Holt & Company, Inc., 1913, pp. 157-158. A Connecticut committee of 1907 refused to recommend a compensation act on the same ground. *Ibid.*, p. 159.

⁹ *Ibid.*, p. 158.

¹⁰ *Ibid.*, p. 158.

¹¹ *Proceedings of the American Federation of Labor Convention*, 1909, p. 27.

their dependents in case of death, were allowed one year's wages. But no compensation was payable unless the injury arose out of or in the course of employment, nor if the injury was due to the worker's negligence or misconduct. Although limited in scope, niggardly in benefits, and crudely drafted, it was nevertheless the first real American workmen's compensation law.

Another embryonic measure was passed by Montana in 1909, effective October 1, 1910, with benefits payable four months later. The act was compulsory but limited in scope to coal mines and coal washers, excluding office employees, superintendents, and general managers. A coöperative, state-administered insurance fund was established into which employers paid one cent per ton of coal and employees 1 percent of gross earnings. For fatal accidents there was a benefit of \$3000; for injury a maximum of one dollar per working day. A waiting period of twelve weeks was provided, but payments began immediately in cases of permanent disability. Loss of one limb or of one eye was compensated at \$1000. The injured worker, or in case of death his dependents, was permitted to sue for damages under employers' liability laws, forfeiting compensation if he did so. The act was held unconstitutional by the Montana Supreme Court.¹² The Court acknowledged the inadequacy of the old system and expressed its belief that compensation was well within the state's police power. But in permitting employers to be sued for damages and also compelling them to contribute to the insurance fund, the act would compel some employers to pay twice for the same injury, and it therefore denied them the equal protection of the laws.

In 1910, New York passed a compulsory act applicable to eight enumerated especially hazardous occupations in building, construction, railroads and explosives, drafted in such a way as to avoid, if possible, all constitutional difficulties. But the New York Court of Appeals in a decision rendered on March 24, 1911, held that the act was "revolutionary," was not a proper exercise of the state's police power, took property without due process of law, and was therefore unconstitutional.¹³ The Court thought that the common law could properly be modified or even abolished, but the liability to pay damages without fault on the employer's part was unknown to the

¹² *Cunningham v. Northwestern Improvement Co.*, 119 Pac. 554 (1911).

¹³ *Ives v. South Buffalo Railroad Co.*, 201 N.Y. 271 (1911).

common law and its imposition was an unconstitutional deprivation of liberty and property. In 1913, New York amended its constitution to authorize the enactment of a compensation law. A United States Supreme Court decision in 1917 upheld the constitutionality of this type of legislation.¹⁴

The Movement Succeeds. After the Federal act of 1908 and the New York act of 1910, the movement rapidly came to a climax. Many state commissions were appointed by the legislatures of 1909 and joint conferences of these commissions were organized. The American Association for Labor Legislation became active and gave great support. The National Civic Federation prepared a "model" bill and was instrumental in having bills introduced in state legislatures. A committee of the National Association of Manufacturers polled 25,000 manufacturers to learn their attitude toward compensation, and of those who replied more than 95 percent were favorable.¹⁵ The Association proposed a plan under which workers would contribute. The American Bar Association established a committee to plan for uniform compensation, although the legal profession had not been very much interested. The American Federation of Labor threw in its support. And several large corporations voluntarily established accident relief systems analogous to compensation. In 1911, five laws became effective, the following year nine more became effective, in 1913, eight more, and four more in 1914. Thereafter the movement spread until it has now covered all states.

How is this great forward surge to be explained? Dr. Rubinow thought that an enlightened public opinion resulting from a knowledge of European experience was not the primary factor.¹⁶ Growing social unrest caused by conditions resulting from a considerable expansion of industry, and by the development of monopolies was, he thought, an important material force. But fully as important was the growing cost of accidents resulting from laws and judicial decisions modifying and liberalizing the common law of damages. Employers increasingly insured their liabilities, and mounting rates led many of them to prefer the definite and possibly lower costs of a compensation system to the indefinite and high costs of employers'

¹⁴ *N.Y. Central RR Co. v. White*, 243 U S 188 (1917)

¹⁵ F. C. Schwedtmann, in *Annals of the American Academy of Political and Social Science*, vol 38, 1911, p 202

¹⁶ *Social Insurance*, Henry Holt and Company, 1913, pp. 165-168.

liability insurance. There was also the growing realization that the old law was inadequate and that progress required a different basis upon which to base compensation.¹⁷

Recommendations of the Committee on Economic Security. The Social Security Act of 1935 did not include provisions relating to workmen's compensation, nor did any of the subsequent amendments. In its report to the President, the Committee on Economic Security pointed out that despite our progress in safety engineering we still have too many accidents, that our state workmen's compensation laws are sadly lacking in uniformity, and that many of those laws are inadequate. The Committee believed that no fundamental change in our system, such as the substitution of the European system of contributory accident compensation for our noncontributory form, or the nationalization of the system, was warranted. But it did make the following suggestions for a long-time program:

(1) The Department of Labor should further extend its services in promoting uniformity and raising the standards of both the safety laws and the accident compensation laws of the several states, and their administration.

(2) The four (now none) states which do not now have accident compensation laws are urged to enact such laws, and passage of accident compensation acts for railroad employees and maritime workers is recommended.

¹⁷ A careful study of available records in one state throws some light on the forces involved. Of existing laws, those of Kansas and Washington were the first to be enacted. In Kansas, organized labor was actively seeking a stronger employers' liability law, and was passively interested in a compensation law. In the 1911 session of the legislature, a general liability bill and a compensation bill were considered. Organized labor favored both, but was more interested in liability. Representatives of employers opposed both. The Joint Committee holding hearings called in the employers' representatives, announced that one of the two bills would be passed, and offered them their choice of the two. They chose the compensation bill as the lesser of the two evils. The law was made elective, not because of constitutional obstacles, but probably to remove any remaining opposition by employers. Thus without public agitation or previous study and in the face of organized labor's preference for liability and employers' opposition to both, a compensation law was enacted. Domenico Gagliardo, "The First Kansas Workmen's Compensation Act," *Kansas Historical Quarterly*, November, 1940.

CHARACTERISTICS OF AMERICAN COMPENSATION ACTS

We pass now to a description of the general characteristics of American compensation acts. Their most striking, and baffling, characteristic is diversity of provisions. No two acts are alike and on nearly every major point for comparison there is great variation. However, it is possible to indicate the major respects in which there is some degree of uniformity.¹⁸

Coverage. Not all, or even nearly all, workers are covered by compensation laws. For in the first place, not a single one of the American acts covers all employments.¹⁹ Agriculture, domestic service, and casual labor are excluded in nearly every act.

The greatest single gap in coverage is agriculture. There are approximately 3 million wage earners engaged in this employment, and occupational injuries occur frequently and many of them are severe. It is estimated that annually there are some 4800 fatal accidents, 16,000 permanent and 291,000 temporary disabilities in agriculture. Not all of these were suffered by wage earners, but since the latter constitute a third of the total engaged in the industry, it is not unreasonable to suppose that they suffered approximately one-third of the accidents. The employment has been generally excluded because farmers object to being included and wield considerable political influence which most legislators fear to disregard.

A few acts do include agriculture. The District of Columbia, Louisiana, Ohio, and Vermont include all agricultural workers, and Arizona includes those employed in the use of machinery. New Jersey includes farm workers and presumes that the farmers choose to come under the act unless they specifically state that they do not care to do so, but farmers are not compelled to insure their risks. Puerto Rico has almost complete coverage of agriculture for em-

¹⁸ For a recent tabular summary as of July 1, 1947, see *Analysis of Provisions of Workmen's Compensation Laws and Discussion of Coverages*, Chamber of Commerce of the United States. See also Samuel B. Horowitz, *Horowitz on Workmen's Compensation*, Wright and Potter Printing Company, 1947, Frank Lang, *Workmen's Compensation Insurance*, Richard D. Irwin, Inc., 1947, Arthur H. Reede, *Adequacy of Workmen's Compensation*, Harvard University Press, 1947, and *Economic Outlook*, January, 1952.

¹⁹ The word state as used in this chapter includes the District of Columbia, the territories of Alaska, Hawaii, and Puerto Rico.

ployers with four or more workers. Many states include hazardous mechanical processes in agriculture, but frequently only where these are "commercial," that is, where they are not conducted by the farmer himself, but by some outside contractor.

Farmers may to be sure voluntarily come under the compensation acts of their states. They rarely do so, however, partly because of high insurance rates and partly because of indifference. Indifference is an important factor, as experience has shown in acts which did not presume election on the part of the employers or employees.

The number and seriousness of home accidents are appalling. It is estimated that in 1952 there were 29,000 fatalities, 110,000 permanent and over 4.2 million temporary disabilities. Of course not all, nor even most, of these are to domestic servants. Over 50 percent of the fatal accidents were among persons 65 years of age or over, and 20 percent among persons under 15. Nearly 2 million wage earners are engaged in domestic service, and there can be no doubt that it is a hazardous employment.

Yet domestic service is excluded from compensation acts except in a few states, largely on the ground that administration would be exceedingly difficult. In California, domestic servants are included if they are employed for more than 52 hours a week, and in New York in cities of over 40,000 private or domestic chauffeurs and servants working more than 40 hours per week if four or more are employed. Voluntary coverage is permissible and possible, but not commonly found.

Other occupations, of less importance, are also excluded. For example, home workers and those selling and delivering newspapers are usually excluded in order to simplify administration and to avoid insurance difficulties. Teachers, preachers, clerks, and many others are excluded on the ground that their work is not hazardous. Public employment is excluded altogether in a few laws and only partially included in an additional one-fourth of the jurisdictions.

The railroad industry, which has more than 2 million workers, is not included in state acts because of the conflict between state and Federal jurisdiction, and there is no Federal act for it, largely because a majority of the men seem to entertain the belief that large damage awards under employers' liability laws bring them more money than they would get under a compensation act. Injuries in purely intrastate commerce are covered by applicable state acts. A

movement to secure a compensation act for interstate commerce is under way.

It has been suggested that the exclusion from workmen's compensation laws of farm workers, domestic servants, and some other classes, and the exclusion of employers having fewer than specified numbers of employees is the result of the belief that the common-law rules as modified by employers' liability acts are essentially wise and just in those employments.²⁰ Those employments, it is apparently believed, are not much different today from what they were when the common-law rules were developed. A better explanation lies in the difficulty and expense of administering a law in the areas excepted. Experience with unemployment compensation laws, however, suggests that inclusion of employers of one or more is administratively feasible.

Coverage is restricted not only by excluding the large occupational groups mentioned above, but also in some states by limiting the application of the acts to hazardous or extra-hazardous industries, which are sometimes listed in the acts. Farm labor and domestic service are frequently excluded in this way. In Wyoming "dude" ranching is listed as one of the hazardous industries, but stock ranching is not, but North Dakota defines a hazardous employment as "any employment in which one or more employees are regularly employed." The New York list is so comprehensive that practically all employments are included. Those states in which this type of limitation is actually restrictive are not highly developed industrially, except Washington. Many states originally limited coverage to hazardous employments in order to avoid anticipated constitutional limitations, and many of these neglected or refused to extend the scope to all industries after the expected constitutional difficulties failed to materialize.

Injuries Excluded. Not all injuries in covered employments are compensated. Injuries resulting from willful misconduct and intoxication and those deliberately self-inflicted are not generally covered, but, because proof is practically impossible, compensation is seldom denied on these grounds. On the other hand, when an injury results from serious or willful misconduct of the employer, cash benefits are sometimes doubled.

²⁰ F. A. Duxbury, U.S. Bureau of Labor Statistics Bulletin No. 536, pp. 122-123.

Within the employments included, compensation is usually payable only for injuries resulting from accidents arising out of and in the course of employment. The formula "personal injury by accident arising out of and in the course of employment" has been interpreted differently by courts and administrative agencies in the various jurisdictions, and there seems to be but little uniformity in the interpretations. An accident may be defined as an external, undesigned, sudden, and usually violent event which injures a worker, externally or internally. The tendency has been towards a liberal interpretation of what constitutes an accident, at times so liberal in fact that workmen's compensation has been made to bear in part the burdens of sickness, old age, and unemployment. This was shown during the Great Depression, for example, by the widespread claims for silicosis compensation, only a portion of which were bona fide.²¹ But quite aside from this abuse, the importance of the accident concept lies in the fact that it does not generally include injury resulting from occupational diseases. The concept does, however, include some diseases of sudden origin, such as a heat stroke or kidney trouble induced by a chill resulting from working waist-deep in cold water.

It is impossible satisfactorily to describe what the phrase "arising out of and in the course of employment" means, but it may roughly be said to mean an accident causally related to the employment which occurred while the injured worker was in the service of his employer. "Out of" refers to the origin of an injury; "in the course of" refers to the time and place of injury.²²

Occupational Diseases. Not a single one of the early American laws made specific provision for compensating injuries due to industrial diseases not accidentally induced, although many of those diseases were known to exist and their seriousness was fully appre-

²¹ Speaking of such abuses during the period following World War I and the years 1929-1933, one business executive has said "Those people were without jobs. They were without money. They were destitute. They had grocery bills to pay, rent to pay. They were out to get a few dollars, and it did not make much difference who paid those few dollars. I know of many, many cases where we were confronted with reopened compensation claims, and the claimant would say in complete honesty, 'I just need money, and this seems to be a way of getting it.' Sometimes a compromise could be effected, sometimes not. It depended on how badly the man needed money." William A. Sullivan, in *Trends in Workmen's Compensation and Employee Benefits*, American Management Association, 1946, p. 2.

²² Samuel B. Horovitz, *Horovitz on Workmen's Compensation*, Wright and Potter Printing Company, 1944, Part II.

ciated. Failure to include them resulted from fear of abuses and also from the fact that many of the diseases, especially those occasioned by dusts, develop slowly and because of labor mobility the final disability frequently cannot be attributed to exposure under any one employer. In a few states, the compensation law has been liberally interpreted to cover some diseases, such as heart disease, tuberculosis, and cancer. Gradually, specific provision came to be made. It may be said that the distinction between accidents and occupational diseases is now tending to become blurred. Where occupational diseases are not covered, the injured worker has the right to sue under the common law and employers' liability acts.

Approximately three-fourths of all acts now provide some occupational disease coverage. In half of these laws, all diseases are covered; in the other half, only diseases, or groups of diseases, specifically listed in the statutes are covered. Where they are listed, the range of diseases included runs from silicosis only to a fairly extensive list of 39 or 40. A good majority of the states make no special provision for establishing the existence of an occupational disease. Those which do generally provide a medical board or commission whose findings of fact on the question are conclusive. A time limit for filing claims is specified, usually one year after injury, death, or last exposure, but in some cases only six months, and for some diseases shorter periods.

Eligibility for death benefits is limited, most generally to a period of one year following the last exposure, although longer periods are not uncommon. In most states, temporary total disability payments made on account of illness are deducted from death benefits. Usually no special provision is made for medical care, but the same provisions are applied as for accidents. The rate and amount of compensation allowed are also generally the same as allowed for accidents. For silicosis, it has been common to limit maximum liability to say \$500 at the time the disease was first covered in the law, and to increase that maximum slowly each month until it is the same as for accidents. Furthermore, it is also quite common to require as a condition of eligibility for benefits, in case of silicosis, a specified period of exposure, usually five years.

Numerical Limitations. Important also in restricting coverage is the practice of exempting employers in covered occupations who employ fewer than specified numbers of workers. Approximately half of the laws do not have numerical exemptions and apply to em-

ployeys of one or more, and about half of our wage earners are employed in those states. The numerical exemptions in the other states range from two in Oklahoma to 16 in Alabama. Only a few states have a numerical minimum which exceeds five. It should be noted that in some of the states the numerical limitation applies only to nonhazardous employments, and in others the limit is not applicable to certain employments, usually mining and construction. On the other hand, there are also found the strange situations, as in Florida and North Carolina, where there are low numerical exemptions but where sawmilling, an exceedingly hazardous employment, is permitted appreciably higher numerical exemptions, with the obvious intention and effect of practically excluding it from coverage.

Compulsory Versus Elective Laws. Finally, coverage is also restricted by the common practice of permitting employers in covered employment who are not exempt by numerical limitations to "elect out." We have here a strange characteristic of American compensation acts. In fewer than half of the states are the covered employers and employees compulsorily included, whether they like it or not, and in more than half of the states the covered employers and employees are given the option of staying out. However, election to come under the act is "presumed" in nearly all of these states, while in the others notice of election to stay out must be given, usually only by the employer.

Those who elect out are subject to the common and employers' liability law. But it is usually provided in the compensation acts that for the employers electing out, the common-law defenses of assumed risk and coservice are abrogated, and that in cases where the injured employee is guilty of contributory negligence damages shall be scaled down in proportion to that negligence. The common-law defenses are, however, available against employees electing out, although in some states only those defenses already available may be pleaded.

Where employers and employees accept the compensation law, suits for damages resulting from injuries covered are not permitted, except in New Hampshire where a worker still has the option of choosing, after he is injured, whether he will accept compensation or sue for damages. If the employer fails to pay compensation due, then the worker may sue under the common law, with all defenses abrogated. In a few states, the worker may also sue if there is an "intent" on the part of the employer to injure, or if the injury is

the result of the employer's gross negligence or willful misconduct.

Throwing the weight of the common law into the scales against those electing out seems to have had the effect, up to 1930, of making all of the laws practically compulsory. But in the dark days of the depression, many small employers chose the greater risks of the common law in preference to the more certain losses under compensation. Another device used by many small employers during the depression was to carry their own risk, and when one of their employees was injured there would be no money to pay compensation.

The effect of all of these limitations is that actual coverage is considerably less than ostensible coverage. It is not known, and never has been, how many American workers are legally covered by workmen's compensation laws. The number is probably between 35 and 40 million.²³

Benefits. The heart of workmen's compensation is the benefits which are provided: their nature, adequacy, and certainty. Just what should be the basic benefit principle underlying workmen's compensation acts is a matter concerning which there is some difference of opinion.

Theories There are two theories. The "compensation" theory is that such acts should "compensate" the injured worker, or his dependents, for the economic losses suffered because of the injury, not only the immediate loss, but the wages which the injured worker is prevented from earning in the future. Those holding this view believe that the consumer should bear all of the costs of production and that the economic losses to individuals resulting from accidents are a legitimate part of those costs. The principle is well stated in the following quotation. Workmen's compensation "recognizes that the wear and tear of the human element in industry represents a legitimate charge, to be taken into account along with other production costs in fixing the selling price to the consumer."²⁴

To the argument frequently made that such economic losses are really reflected in higher wages and are already included in prices, the proponents of this view point out that this has not been clearly demonstrated and that it is probably not true. And they insist that

²³ Dorothy McCamman and Alfred M. Skolnik, "Workmen's Compensation: Measures of Accomplishment," *Social Security Bulletin*, March 1954, p. 4.

²⁴ C. W. Roberts, *Proceedings of the 19th Annual Meeting of the International Association of Industrial Accident Boards and Commissions*, U. S. Bureau of Labor Statistics Bulletin No. 577, 1933, p. 179.

even if it should be true, it would be socially desirable to provide for the losses by means of a compensation law rather than by higher wages, because of. (1) the economic loss involved when each worker carries enough reserve to meet the hazard falling upon only a few; (2) the insufficiency of income of the average employee; (3) the indifference, or lack of foresight, of employees; and (4) by providing compensation, and putting the cost upon the employer in a form recognizable as payment for accidents, there is brought to bear upon the employer pressure to eliminate or to reduce accidents. Indeed, the ultimate aim is held to be the prevention of accidents.

The compensation theory appears to reflect the common-law principle of damages, with this difference, that it attempts to bring about a closer correlation between economic loss and the damages received, to make payments more certain, and to eliminate as much as possible all litigation and delay.

But there is another theory. Some believe that the purpose is not, or should not be, to compensate the injured worker, but rather to "readjust" him in a way as to make him, or his dependents, independent and self-supporting. Unlimited medical benefits should be provided, and such payments as are necessary for existence during the period of rehabilitation.²⁵

This may be called the "rehabilitation" theory. It is based on the assumption that "society is not interested in making an injured worker as well as he was before, in restoring to him everything he has lost, by way of money damages." The two grounds advanced in support of this view are first that it is practically impossible to determine the economic loss involved, and second that to pay the actual losses would break down any system. It is also suggested that to compensate fully would lead to malingering. The burden of economic losses caused by industrial accidents, it is held, should rest where they fall, unless they can be attributed to the fault of some one else. If they can be so attributed, the principles of the common law, as modified by employers' liability acts, should be applied, outside of the workmen's compensation system. It might also be argued that higher wages in hazardous occupations take care of the compensation element. As noted above, proponents of the compensation theory deny that this is the case.

These theories have had little, if any, influence on the movement.

²⁵ F. A. Duxbury, U.S. Bureau of Labor Statistics Bulletin No. 536, pp 121-132.

One authority has said that in practice benefits "are based upon no recognizable principle and in most cases bear little relationship, either to the needs of the injured workers or their dependents or to the loss of earning power resulting from the injury."²⁶ In respect to the relationship between benefits and loss of earning power, however, workmen's compensation is better than the common and employers' liability law.

Cash Benefits There are two kinds of benefits: cash and medical. One would suppose that after approximately forty years of experience, a reasonable degree of uniformity would have been achieved. On the contrary, the diversity has not only continued, but has become increasingly great. The following general description of the principal features of cash benefits must be read with this fact in mind. It should be useful, although it does not pretend to achieve a high degree of accuracy.

Every act but one, that of Oregon, has what is called a waiting period following an injury before cash compensation payments begin. The object of a waiting period is to eliminate from the system of cash payments the enormous number of relatively minor injuries which cause little loss and which, if included, would greatly increase the cost of administration. The waiting period also makes possible larger benefits for more serious cases, and it tends to prevent fraudulent malingering. Most of the acts, over 70 percent of them, have a seven-day waiting period, about 23 percent have shorter and the rest longer periods. The range is from one to 14 days. However, in most cases, compensation is made retroactive and thus covers the waiting period if disability lasts beyond a specified time, most commonly four weeks.

The cash benefits paid to injured workers are based on wages. Usually under any given law the same percentage of wages is paid for all types of injury, but in some states the percentage varies according to injury or size of family.

In a few acts, the widows of workers killed in industry are paid benefits for life or until remarriage, and dependent children are paid until they reach a specified age. The percentage of the deceased's wage that will be paid ranges from 50 to 70, and is most commonly 66%, with a maximum weekly amount most commonly between \$18 and \$25 and a minimum most commonly between \$5

²⁶ Carl Hookstadt, quoted in W. F. Dodd, *Administration of Workmen's Compensation*, Commonwealth Fund, 1936, p. 628.

and \$10. About one-fourth of the states have a higher weekly maximum for widows with children than for widows without children. Seventy percent of the acts specify a maximum number of weekly payments to be made, usually between 300 and 400, and absolute maxima usually from \$5000 to \$8000 where there are no children. One-fourth of the acts have neither maximum total amounts nor maximum durations. Payments made to widows cease upon their remarriage. Arbitrarily limiting the time during which benefits will be paid or their total amount would seem to defeat the fundamental purpose of workmen's compensation by terminating payments when the need for them continues to exist. The Oklahoma act makes no provision for death benefits because the constitution of that state forbids any such action. Modest funeral benefits are provided by all acts except that of Oklahoma.

Permanent total disability benefits are paid for life in approximately 40 percent of the jurisdictions. The weekly rate ranges from 50 to 70 percent of wages, and is most commonly 66% percent, with a minimum usually of from \$7 to \$10 and a maximum usually from \$25 to \$30, with additional amounts allowed for dependents in a few states. The Federal Civil Employee's and the District of Columbia acts have gone a step further and authorize as much as \$50 per month additional in cases where the disabled person needs the services of an attendant constantly, and Nevada also allows additional sums under such circumstances. Several acts allow additional amounts if the disabled employee is undergoing vocational rehabilitation.

Most of the acts, however, pay not for life and not even for the entire period of disability, but pay only for limited maximum periods of time, most commonly from 400 to 550 weeks. It is common, even where there is no specified maximum number of weekly benefits, to impose absolute dollar maxima, most commonly from \$6000 to \$10,000. For the lower-income group, the specified maximum total is more favorable than the limited number of weeks.

For temporary total disability, benefits are calculated in the same manner as for permanent total disability and have the same maxima and minima, but the specified maximum duration in some states is shorter. Here again a few acts provide payment for the entire period of disability, but strangely enough this is not true of all the acts which provide life payments to those with permanent total disability.

The maximum amounts that will be paid are most commonly from \$5000 to \$10,000.

Compensation for permanent partial disability presents special difficulties and is made in several different ways. Where the injury suffered consists of the loss of a part of the body, or of its use, it is usual to pay fixed numbers of weekly total disability benefits for specified portions of the body. Wisconsin, which pays the highest benefits and appreciably more than most other states, as of July 1, 1946, paid a maximum, in addition to compensation for the temporary disability involved, for the loss of an arm at the shoulder, \$12,950, for a hand, \$8633; for a thumb, \$3338, for an index finger, \$1295, for a second finger, \$1036, for a third finger, \$777, for a little finger, \$777. For the loss of a leg at the hip, the state paid a maximum of \$12,950, for a foot, \$6475; for a great toe, \$258, for any other toe, \$648. For the sight of one eye, the state paid \$7123, for the hearing of one ear, \$1295, and for both ears \$8633.

In 30 percent of the acts, payments made for temporary disability are deducted from the benefits allowed for scheduled injuries such as these. In 50 percent of the acts the payments for scheduled injuries are in addition to the temporary disability benefits paid during the healing period, and in about 20 percent the amount of temporary disability benefit is limited²⁷

Where the injury does not consist of the loss of some member, as in the case of internal injury, it is customary to pay a percentage, say 50, of the resulting loss in earning capacity, with weekly minima and maxima, and not infrequently for limited periods of time. Here too, the payments are in some states in addition to and in others exclusive of payments made during the healing period.

²⁷ It is probable that the idea of these schedules of injury payments carried over from the Anglo-Saxon codes of the Middle Ages, in which "the compensation to be given for various offenses was stated in terms of money, for striking off the nose the payment was sixty shillings, for a forefinger fifteen shillings, for a forefinger nail four shillings." Herbert Heaton, *Economic History of Europe*, 1936, pp 182-183. The practice existed in ancient times. Recently a Babylonian tablet containing what is said to be "the oldest system of laws known to man," was found, written between the 20th and 19th century B C. Like Hammurabi's Code, this code of Bilalama laid down penalties for mayhem: "If a man bites another man's nose and severs it, he pays one mina of silver. (For) an eye (he pays) one mina of silver, a tooth a half mina of silver, an ear a half mina of silver, a slap in the face 10 shequels of silver." *Associated Press* news report, March 28, 1948.

In nearly all jurisdictions, benefits are based on normal full-time yearly earnings rather than on actual earnings. An extreme example of the differences in methods of computation is shown in the case of a totally disabled worker in Pennsylvania who was at first awarded a weekly benefit of 57 cents, based on actual earnings, but which benefit was later computed on the basis of normal full-time yearly earnings and raised to \$15. Even when based on full-time earnings, benefits are small in most states. It is probable that the injured worker does not receive as much as 40 percent of his actual loss in wages.

The major factor determining benefit scales seems to be loss of earnings, but the desire to reimburse for disfigurement, the hope of stimulating employers to reduce accidents, the need for rehabilitation, and protection of minors have also exerted some influence. The wealth of states has also been a factor. During the Great Depression, there was a slight tendency to reduce the scales and even to eliminate from the scope of compensation some industries with higher risks, no safety codes, and no insurance regulation. But the trend was reversed during the defense and war period.

Determinations involving periodic payments, whether made by courts or by special agencies, are in nearly all states subject to later review if either side claims that a change in the injured worker's conditions warrants such action. They may also be reviewed where either side claims that there was fraud in the original determination. Although inconvenient, expensive, and subject to some abuse, especially in depressed times, areas, and industries, the practice of modifying awards as disability changes, if properly safeguarded, is in line with the fundamental principles of workmen's compensation.

Promptness in making the first payment to injured workers is important. Unfortunately, considerable time is required to make the necessary arrangements. In states having monopolistic funds the first payment generally requires more than 30 days. In states permitting agreements or direct-settlement, the time averages only slightly less. A few states have established excellent records in respect to promptness of benefit payments.²⁸

The average level of benefits has increased substantially over the years. From 1918 to 1929, the level increased 31 percent. During the depression years 1929 to 1936, there was practically no change in

²⁸ See Frank Lang, *Workmen's Compensation Insurance*, Richard D. Irwin, Inc., 1947, chap. ii

benefits. Thereafter the increase was resumed, and by 1946 the level was 50 percent higher than in 1918.²⁹ Further increases in benefits have been made since then.

Medical Benefits Medical benefits, which in the beginning of the movement were woefully inadequate, have come to play an important role in the American compensation system, and constitute from one-fourth to one-third of the total benefits paid. They are vitally important because on their quality and adequacy depend the rate and extent of recovery from injuries, the amount of compensation paid to injured workers, the cost of insurance, the scope of practice among doctors, and the welfare of injured workers and their dependents. Furthermore, an injured worker covered by a workmen's compensation law who incurs a medical bill greater than the amount allowed him by the act has lost his common-law right to sue for recovery, although it should be added that that common-law right did not usually serve him very well in the past.

Every compensation act now provides medical care, which is available immediately upon injury. The cost of this care is borne wholly by the employer under practically all acts. In Alaska the worker may be charged \$2.50 per month, and in Arizona and Nevada one-half the cost, but not more than \$1 per month. In Washington the law formerly required that one-half the cost of occupational disease compensation be borne by the worker, but that provision was repealed in 1939. In Colorado, Idaho, Kentucky, Montana, and Oregon the workers may be required to contribute part of the cost of cooperative hospitals. In Oregon workers pay one cent per day towards the cost of compensation, which may be thought of as meeting a part of the cost of medical care.

The amount of medical and hospital care allowed to injured workers varies greatly among the many jurisdictions. In 1952 there was no limit in the amount of care or in the time during which such care had to be provided in two-thirds of the jurisdictions. The remaining third limited either the amount or the time or both. In the four jurisdictions limiting only the amount to be provided, the maximum specified ranged from a high of \$2500 to a low of \$500. Five jurisdictions limited the time but not the amount, and the time varied from one year to four weeks. Nine jurisdictions limited both time and amount; the best combination was nine months and \$1000 and

²⁹ George E. Peterson, in *Trends in Workmen's Compensation and Employee Benefits*, American Management Association, 1946, pp. 5-6

the worst was 120 days and \$100. However, quite a few acts authorize the administrators to allow additional services in special cases, with the result that in practically three-fourths of the states there are for most injuries neither time nor amount limits. It might be added that in many cases insurance companies voluntarily pay more medical benefits than the maximum specified in the law. Artificial appliances are made available in almost all of the laws.

Despite the fact that improvements in medical aid provisions represent the greatest single advance in the development of American compensation acts, most of the states still have a long distance to go before it can be said that their injured workers are receiving adequate medical care.

The question of how the attending physician shall be chosen in case of injury has been and still continues to be troublesome. Various arrangements are to be found. In some cases, the employer or the insurance company chooses the physician; in others the employee chooses from a panel of doctors drawn up by the employer or insurance carrier or by the state compensation authority in coöperation with medical organizations, and in still others the worker chooses whomsoever he pleases. Free choice by the worker, except at his own expense, was rare in the early days of the movement, but the trend has been in that direction for some time.

Compensation costs have been found to be greatest under free choice of doctors by injured workers, largely because family physicians are relatively inexperienced in treating industrial injuries, and also in part because frequently family physicians hesitate to certify that their patient is able to work when that patient himself is not anxious to return to his job, as sometimes is the case. However, no arrangement is free from defects or abuse. Although recovery is more rapid under a system of directed choice, there have been cases where employers or carriers have put on the panels incompetent physicians, or men who were more interested in finding for the company than in treating the injured worker. The abuses to be found in medical aid have recently been receiving considerable attention, and there is reason to expect that some improvement will result.

Insurance. Liability to pay compensation and to provide medical benefits is placed on the employer, who is also made to bear practically the entire cost. Nearly all of the acts also require that

the employer insure his risk, although most states permit employers to carry their own risk, subject to approval by the compensation authorities.

Private casualty insurance companies insured the employer's liability under the common and employers' liability law, and a standard policy was developed to cover that risk. Private carriers are permitted to write workmen's compensation insurance in all but eight states, where there are monopolistic state funds.

There has been developed the Universal Standard Workmen's Compensation Policy, which is used in nearly all states. According to the terms of this policy, the insuring company assumes the obligations imposed by the compensation law, and any liability that may exist under the common and employers' liability laws as well. The laws are thus "read into" the contract. The carrier assumes all of the employer's compensation liability, or stands in his place. However, in most states the insured employer does not completely shift the risk, for if the carrier fails, the employer is still legally liable to make compensation payments. The employer's relation to the carrier is contractual, but his relation to his employees is statutory.³⁰ Only in some of the states having exclusive funds and in a few other jurisdictions is the employer's risk absolutely shifted to the carrier.

Insurance premiums are based on pay roll. The premium paid when a policy is written is necessarily an estimate, since total pay roll for the year is not known, and at the policy's expiration a pay-roll audit is made and the necessary adjustments take place. Extra-hazardous classifications may be charged as much as \$20 per \$100 pay roll, although the average rate is somewhere around \$2. Other possible bases have been studied, but the pay-roll base has decided mechanical advantages. In any event, rates must cover costs, and costs depend on benefits and expenses. Any rate levied on any base must cover costs if it is to be continued.

Basic premium rates for most states are established by the National Council on Compensation Insurance and its regional committees, a rating organization composed of about 150 members, including stock and mutual companies, reciprocals, and competitive state funds, operating under a plan approved by the National Asso-

³⁰ For a summary statement of the law, see Arthur Lenhoff, "Insurance Features of Workmen's Compensation Laws," *Cornell Law Quarterly*, vol. 29, 1943-1944, pp. 176-202, 353-379.

ciation of Insurance Commissioners. There are also 11 independent rating organizations serving as many states and two state rating boards. Monopolistic state funds establish their own rates.³¹

On the basis of data submitted by carriers of all types for many years, the Council has constructed a highly developed system of risk classifications, and refinements are constantly being made. There are approximately 700 such classifications, based on the degree of hazard present in business operations.

Each carrier cooperating submits its experience with each policy soon after the policy's expiration, including pay roll, rate, premium by classification, number of losses, costs, and other pertinent detail. The Council or rating bureau assembles the policies by the years in which they were issued. From the experience on these policies, there is developed a "pure premium," which in general represents the actual cost of compensation benefits paid. This "pure premium" is then adjusted in various ways to project it to the level which other factors are expected to bring it during the following year, such factors for example as amendments to compensation acts. The pure premiums so derived are then compared with those underlying the rates used in policies the experience under which is being considered. Where the size of experience used for any classification appears to be inadequate, adjustments are made. Further adjustments may be made to give an overall rate level estimated necessary to meet total losses. These pure premiums are then multiplied by an "expense multiplier" to get the final rate. The result is called the "base" or "manual" rate, is revised every year and published in manual form.

The rate actually paid by any given employer, however, is determined by a "merit rating" system. The first system so used is known as "schedule rating." The manual rate was credited and debited on the basis of the observance of certain safety standards. Schedule rating has for the most part been replaced by other methods, but it was still used in three states in 1946.

A different system, known as "prospective experience rating," was developed. In this method, experience under preceding policies is applied in determining what modifications to make in the new policy rate. Where fairly large risks are involved, the method works very well. But for small risks, the projection of past experience into

³¹ For a fuller description of rate making, see Frank Lang, *Workmen's Compensation Insurance*, Richard D. Irwin, Inc., 1947, chap. v.

the new policy year has relatively little validity, and the method is not generally used.

A more recent development is known as "retrospective experience rating." It is not a substitute for the other two, but may be used to supplement them. Retrospective rating is a device which aims to relate more closely the cost to an individual employer of his own loss experience and the cost of administering his policy. It is a "cost-plus" proposition.

The employer who is insured under this plan pays a basic premium covering costs which do not vary directly with his losses, such as administrative expenses and taxes, and he is charged the "standard" premium. But he can "earn" back a part of that standard premium by reducing his accidents and his compensation costs. Each risk thus stands by itself under retrospective rating, at least beyond the minimum premium. Retrospective rating is "insurance and service up to the minimum premium—service in connection with losses from the minimum to the maximum premium, and insurance and service, again, in event that the maximum premium is exceeded."³²

Substantial savings have accrued to those using the plan. In New York from July 1, 1937, through January 1, 1946, a group of 1689 risks with a total standard premium of \$68,695,442 saved \$11,523,400, or 16.8 percent.

High wages and full employment result in low insurance rates. These rates are then applied in the subsequent period of recession or depression with its reduced wages and employment. From 1918 to 1923, rates declined 10 percent, then increased until 1937, when the rate level was 55.9 percent above 1918. During the years 1923 to 1936, carriers consistently lost money. As wages and employment increased, rates began to decline and by 1946 the rate level was only 12.3 percent above 1918.³³

Private carriers have refused on occasion to write policies for certain occupations and individuals. One method of meeting this situation in some states has been for the compensation authority to allocate the unwanted risks among the several carriers according to some plan. But this has not proved to be very effective. Private carriers have sometimes failed, with resulting losses to injured workers entitled to payments. In a few states, insurance carriers are required

³² George E. Peterson, in *Trends in Workmen's Compensation and Employee Benefits*, American Management Association, 1946, p. 9

³³ *Ibid.*, p. 6.

to contribute to a special fund out of which benefits are paid in case of any carrier's failure.

Eleven states have established their own insurance funds, which operate in competition with private carriers in those states. There is now but little opposition by private carriers to these competitive funds, largely because the state funds usually must insure all rejected risks. In 1942, private companies carried 79 percent of all workmen's compensation business in states with competitive funds, and their business has increased considerably more than that of the state funds. All but three of the competitive state funds were established in the original compensation acts of the states concerned, all dating back to 1917 or earlier. There has not been a trend toward competitive state insurance.

There are eight exclusive, or monopolistic, state funds, and in these states private carriers are simply not permitted to sell compensation insurance. The Arizona competitive fund writes nearly all of the compensation insurance in that state and is therefore almost like an exclusive fund. Self-insurance is permitted in some of these states, but where it is permitted the state fund pays compensation to injured workers whose employers have not insured and who themselves fail to pay. All but one of the exclusive funds were established by the original compensation act. Nevada established her fund two years after the original act was passed. Puerto Rico started out with an exclusive fund in 1916, went to a competitive fund in 1928, but returned to an exclusive fund in 1935.

This lack of tendency for state funds to spread is explained in part by the opposition of established casualty insurance companies to any expansion and in part by the fact that, although there is no "profit motive" in their operations, yet because of inadequate appropriations, political turnover of personnel, and the necessity for making a fair financial showing, the handling of claims has not been much, if indeed any, better than by private carriers. The best private carriers have rendered more and better services of certain kinds, accident prevention for example, than have the state funds. None the less, many believe that the entire system might well be "socialized," the state serving as carrier. For the more carefully private carriers are supervised, it is said, the more duplication of functions exists. That is the recommendation of state compensation officials, consistently repeated at their annual conferences.

Two important differences between state funds and private car-

riers are found. State funds sell only workmen's compensation insurance, while private carriers generally sell other forms of casualty insurance, such as auto liability, burglary, and property damage. State funds sell only within the limits of their states, while private carriers may and usually do sell everywhere.

There are different types of private carriers. A stock insurance company has its stockholders, board of directors, and officers, and is organized and operated for profit. Business is generally solicited by agents paid on a commission basis. A mutual company is an association of policy holders with its board of directors and officers. Insuring employers are the policy holders, they share in the liabilities and share profits of the company in the form of dividends. Business is solicited through salaried employees. Many mutuals are so much like stock companies that it is difficult to distinguish between them. The Reciprocal or Interinsurance exchange is another form of organization. Policy holders, known as "subscribers," authorize a designated individual, known as an attorney-in-fact, to conduct operations for them paying him usually a specified percentage of gross premiums or deposits. The subscribers bear the liability, sometimes jointly, sometimes jointly and severally.

Nearly all states permit the employer to carry his own risk, that is to be a self-insurer, provided the compensation authority permits. Such permission is granted by the state compensation authority or insurance department on a showing of adequate financial responsibility. Few large companies permitted to carry their own risks have failed to pay compensation costs incurred. It is common also to permit employers who are thus serving as their own insurance company to reinsure a part of their risk, i.e., to contract with others to furnish medical care to their injured employees, and to adjust claims for compensation. Large employers whose risks are so spread in time and place that the law of probability will apply to them, and who have well-developed safety and medical programs, can safely and economically carry their own risk, except perhaps for catastrophes, but the saving is not as great as some would suppose. Reserves accumulated by self-insurers are not deductible as expenses in income-tax returns.

Where properly supervised, self-insurance has worked satisfactorily. But too often, especially in depressed times, areas, and industries, small employers are permitted to carry their own risk, and that really means not self-insurance, but no insurance. Even when

required to insure, many small employers deliberately fail to do so. They are to be sure subject to suit for damages and in some cases to prosecution. But the futility of prosecution for failure to comply is shown in the experience of New York in 1936 when in an unusually intensive campaign, supported by several employers' associations, against employers without insurance, convictions were secured in 1384 cases out of 1699, but jail sentences totaled only 2110 days and fines \$4176. The drive did, however, result in collecting the major portion of compensation due to the injured workers.

Administration. Under the common law, the employer's liability to pay damages and the amount to be awarded were determined altogether in the courts, frequently in a trial by jury. One of the striking characteristics of workmen's compensation legislation is the machinery established to administer the laws. In only six states are the rights and obligations set forth in the acts left to the courts to administer. Most states have established special agencies for administering compensation legislation, usually a commission, but sometimes only one commissioner. The commissioners are generally appointed by the governor, with the result usual in American states that political considerations are frequently the most important in making an appointment.

A harsh and stinging criticism of political administration, one which is surely a great, if not a gross, exaggeration, was made by one student of labor problems, who said that not only were most of the acts being administered by "underpaid, mediocre, unqualified men," but that "some of these men are actually trading in the arms and legs and lives of their fellowmen; and many others, if not grossly dishonest, are at least grossly hard and unfair."³⁴

The task of administering compensation legislation is manifold. First and foremost is the necessity of determining whether an injury is covered by the law. If the injury and worker are covered by the act, it is then necessary to determine the nature and extent of that injury. Then follows the problem of computing the amount of compensation to which the worker or his dependents is entitled. Medical aid presents similar matters for determination. But the task is not completed when these determinations are made. For workmen's

³⁴ E. E. Cummins, *The Labor Problem in the United States*, D. Van Nostrand Co., Inc., 1932, p. 730. This passage remains unchanged in the 1947 edition, which is a revision made by Professor Frank T. Devyver, p. 535. For a more temperate view, see *Horowitz on Workmen's Compensation*, pp. 284-290.

compensation has substituted pretty generally periodic payments for the lump-sum judgments of the common law. It is necessary to see that these payments are made regularly and in accordance with the law. All laws permit the commutation of periodic payments under certain conditions, and it is necessary that the commutations be properly supervised. Factory inspection, the prevention and reporting of accidents, and vocational rehabilitation should also be integral parts of the administration of workmen's compensation, but except for accident reporting they rarely are. Different methods of carrying out these functions are used in the various jurisdictions

Three systems for settling compensation claims are found in those states in which employers may insure their risks in private insurance companies, all three usually existing together: direct-settlement, agreement, and the "hearing" system. It may be noted here that nearly all acts require as a prerequisite to compensation that the employee give notice of injury to his employer or the employer's agent, usually in writing, the object being to afford the employer or his insurance carrier an opportunity to investigate and to test the worker's good faith. But the requirement is not absolute, for notice of injury is not necessary if there is sufficient reason for not having given it, if the employer has actual or constructive knowledge of the injury, or if failure to give the notice has not prejudiced the employer's cause

In the direct-settlement system, the employer or his insurance company determines the amount due and begins making payments immediately. There is no agreement with the employer and no initial determination is made by the state administrative agency. However, the employer's determination of the amount due is subject to a supervisory check by the compensation authority, which decides on the basis of reports made by the employer or after a conference or hearing whether the amount is correct.

The agreement system differs primarily in the fact that either before or after compensation payments begin the employer and employee reach an agreement as to the amount due. That agreement is valid only if the settlement is in accordance with the provisions of the compensation law, and it is subject to the compensation authority's approval, which may be withheld on the basis of reports or a conference or hearing. In states with compensation authorities, all such settlements are reviewed. Before the Great Depression, about 90 percent of the claims for compensation involved no contest, but

during the depression the number of contested cases increased considerably. Workers were trying to get more and employers were trying to pay less.

It is amazing that the amount of compensation due should be left to agreement between injured workers and their employers, or insurance companies. The extent of injury is a matter requiring the professional judgment of a qualified physician and certainly is not a matter on which a worker could be expected to have any judgment. Furthermore, a worker can hardly be expected to know the provisions of his state's compensation law. The practice violates a fundamental principle of social insurance, namely that the amount of benefits payable should be determined by the state and not left to individual settlement.

How the agreement and direct-settlement systems work out is suggested by the results of an investigation of 1000 cases made in New York in 1918.³⁵ One hundred and fourteen agreements in cases involving serious injuries and which had been approved by the compensation authority were investigated. In 200 cases, employers' accident reports were missing from the files, and in 714 cases reports of attending physicians were found to be missing. Many physicians' reports present had misleading descriptions of the injuries involved.

Injured workers had been paid \$13,712.40. After the investigation, the commission made additional awards of \$52,279.84, an average of more than \$450 per case. The agreements were thus made for slightly more than 20 percent of the amount which the commission decided was due under the law. Many of the agreements filed with the commission were found to have misstated the wage, that probable wage increases of minors had not been considered, that retroactive compensation for the waiting period in disabilities lasting more than a stated time had not been made, and that the seriousness of some disabilities had been understated.

None of these cases involved the state insurance fund. But the investigation also revealed that the state fund favored some employers by cutting the compensation of their injured employees, the underpayment amounting to \$11,326.96 in 18 cases, an average of about \$630.

Administration of state laws in states permitting agreements and

³⁵ Jeremiah F. Connor, *Report to the Governor of New York, Legislative Document No. 26, 1920*, summarized by W. F. Dodd, *Administration of Workmen's Compensation*, pp. 169 ff.

which have compensation authorities has greatly improved since 1918, and the abuses now existing are certainly not so serious. But relatively few compensation authorities are sufficiently well financed to enable them to determine accurately whether a multitude of settlements conform to the provisions of the state's law. The whole story is not always in the reports. There really can be no certainty that serious abuses do not exist, or that they will not again become common. In states with court administration, underpayment is probably more prevalent than in states with compensation authorities.

The abuses can be appreciably lessened if accident reports are made by employers rather than by insurance carriers, if the compensation authority advises injured workers of their rights, if no agreement is approved unless a physician's report is made, if payments are made to the claimant or to his order, and if the agreement is not made a bar to further proceedings³⁶

It is not uncommon to permit employers and employees to compromise claims for compensation in cases where there is a dispute as to the employer's liability or as to the extent of the injury, but usually only with the approval of the compensation authority. Although something can be said in their behalf, too often these compromise settlements result from insurance carriers' attempts to hold down costs at the expense of the injured and ignorant workers, and compensation authorities have been too lax in giving approval.

In a thorough-going "hearing" system, all injuries would be followed by a public hearing by the compensation authority and the amount of compensation due, if any, would be determined by the state after the hearing. New York tried this from 1919 to 1936, but the cost and wage losses of attending workers were so great that hearings were limited to cases that appeared to be compensable.³⁷ Contested cases are of course always heard, usually by a commissioner or deputy commissioner. In contested cases, the worker in order to be heard must always file a claim or application for compensation with the proper administrative agency. This must be done for all cases, whether contested or not, in states with monopolistic insurance funds. It is becoming more common to hold "prehearing conferences" in which informal consideration is given to contested claims.

³⁶ W. F. Dodd, *Administration of Workmen's Compensation*, pp. 181-185.

³⁷ For a more detailed description of these systems, see U. S. Bureau of Labor Statistics Bulletin No. 672, pp. 118-128.

The burden of establishing his claim for compensation, whether before a referee, commission, or court, rests with the injured worker, or in fatal cases with his dependents, although in some states it is presumed that the injury is covered by the act and that it was not willfully incurred or the result of intoxication, that sufficient notice was given, and that medical and surgical reports of doctors for the claimant constitute *prima facie* evidence of the medical facts.

As a general rule, the procedure followed in hearings is simple and informal. Only one act, that of Alaska, provides that evidence introduced in hearings shall be in accordance with the "rules of evidence" developed by the courts. In all other jurisdictions, more or less freedom exists to introduce any evidence that might be helpful. One of the important rules of evidence relates to hearsay. In compensation hearings, hearsay evidence may be introduced, and if not objected to by the opposing party it will stand. Where there is objection, it usually will also stand. But the general practice is that an award cannot be based merely on hearsay evidence, but must be supported by some "legal" evidence. Circumstantial evidence also is admissible, but an award must be based on more than speculation, surmise, or conjecture. Commissioners may also consider generally known facts, and evidence which can be observed but not introduced into the record—how the injured employee acts, for example. Relaxing the rules of evidence has, on the whole, been beneficial, but it has brought problems of its own, such as awards based on what appears to be the flimsiest of evidence.

When hearings are held, the main purpose is usually to determine the extent of the worker's injury. Medical testimony is important. Some of the difficulties facing the compensation authorities are suggested here: ³⁸

If some injured workers are not already "shell shocked" or neurotic before they attend a hearing and listen to the medical testimony, they are indeed hardy and nonsuggestible if they leave the hearings in other than a hopeless state of mind. It is a common occurrence for medical witnesses, in order to obtain a maximum disability rating for the worker, to testify loudly and emphatically that the injured man will never be able to resume his accustomed occupation, that he is seriously and permanently disabled, that his condition will get worse instead of better, and as an occasional climax that the worker may die soon.

³⁸ Marshall Dawson, in U.S. Bureau of Labor Statistics Bulletin No. 672, p. 127.

Usually, the insurance company is not legally required to explain to an injured worker what his rights are under the compensation law. The picture of medical testimony from the insurance company's or employer's side is as dark as from the worker's side, as the following quotation makes clear: ³⁹

. . . Insurance company practice in the chief industrial centers of each jurisdiction studied is, on the whole, restricted to a relatively small group of doctors whose written reports and findings and verbal testimony favor their employers, the insurance companies, with monotonous regularity. The conclusion is inescapable that most of these doctors are selected or retained for their legal ability in defeating employee's claims rather than for their medical skill in healing their injuries.

In order to resolve such conflicts in testimony, compensation authorities, or courts, may appoint independent physicians to examine the injured worker and report on the nature and extent of his injury. The practice of appointing neutral physicians is also used to decide cases in which malingering is charged. Malingering resulting from workmen's compensation is common enough to have been given the special designation of "compensation neurosis." ⁴⁰ The practice, with modifications, has also been used to prevent excessive charges made by some physicians, and excessive charges have not been uncommon.

Lawyers are not immune from criticism, as is shown in this description of hearings under the Illinois act. ⁴¹

In conducting the examination and cross-examination of witnesses, every lawyer uses his own methods and devices. In few cases does the purpose seem to be the clear presentation of all the facts. Some attorneys are overbearing and treat witnesses, especially timid ones, as though they were felons. Some endeavor to drag all kinds of extraneous matter into the record for the purpose of confusing the issues. One insurer's attorney, as a major element in his strategy, adopts the policy of insinuating that claimants are moral degenerates. In some cases the representatives of insurance companies deliberately extend their questioning to as great a length as possible merely to make the record so long, and therefore so costly to transcribe, that the claimant cannot afford to appeal from the arbitrator's decision should it be against him. Some lawyers make stand-

³⁹ W. F. Dodd, *op. cit.*, p. 491.

⁴⁰ Joseph Aub, M D, in U S. Department of Labor, Division of Labor Standards Bulletin No 2, p. 142.

⁴¹ W. F. Dodd, *op. cit.*, p. 491.

ardized "wise cracks" at appropriate times to cloud the issue. One has his "black book" in which he has written down and classified his "wise cracks" and quotations from the testimony of medical witnesses at previous trials, and which he uses to discredit the testimony of these witnesses when they appear against him. Many lawyers often succeed in requiring yes-or-no answers to questions that cannot properly be answered in this way because of the complexity of the subject matter. This may not only prevent the whole truth from being brought out but may also distort the meaning of the witness.

Court Administration and Appeal. In states where there is no compensation authority, of which there are still six, the administration of claims is left to the courts. In effect this means that the amount due is determined by direct settlement or agreement, without any supervision except in contested cases. It is common to require that copies of agreements be filed with the courts, but for the most part the courts are interested in knowing whether the agreement is in proper form rather than in whether it represents a just evaluation of the amount of compensation due. Contested cases go to the courts for determination, and the courts decide how much is due under the law and the facts. But their decisions are generally without the benefit of expert knowledge of the industry, accidents, medicine, and the intricacies of the compensation law, and without the benefit of accident and inspection reports and other supplemental information available to a state compensation authority. Underpayment and delays in the settlement of contested cases are said to be greater than under any other form of administration.

In states with compensation authorities, appeal to the courts is permitted, except in Nevada. That makes it necessary or desirable for the compensation authority to handle contested claims in something of a legalistic manner, at least with one eye to what the judiciary may do if an appeal is taken. It becomes desirable for the worker to employ an attorney, which reduces somewhat the net value of his award. Appeal to the courts has generally been considered necessary in order to prevent abuses in claims and administrative process, and to establish uniformity and consistency in the interpretation and application of compensation laws.

Courts of first instance are generally district or county courts, but in some states appeals from decisions of compensation boards or commissions are taken directly to the state supreme courts. As a general rule, courts pass only on questions of law, the facts as found

by compensation authorities being binding. In a few jurisdictions, however, the courts also pass on questions of fact. Trial by jury is practically nonexistent.

Most laws provide that where the worker is successful on appeal, partial or total reimbursement of "reasonable" attorney and witness fees will be allowed. These are sometimes also allowed when incurred at commission hearings.

It may be well to point out here the fact that the legal profession has not been especially interested in workmen's compensation. Appearing before a group of lawyers, one man said:

Workmen's Compensation may be said to be not unlike a stepchild in the field of American jurisprudence. Perhaps its want of legal parenthood and lack of tradition accounts for the slight consideration it has had from the organized legal fraternity and from recognized law schools. Until quite recently, compensation was accorded almost no recognition in your profession, although the subject had for many years obtruded itself upon the courts, and the decisions in compensation appeals had filled many hundreds of pages in the law reports.⁴²

Further light on the profession's indifference is shed by a legal scholar who writes:

When, about a generation ago, the first workmen's compensation acts made their appearance in this country, their fascination for a profession imbued with the 19th century tort doctrines resulted upon the excision of the defenses of contributory negligence and assumption of risk from actions for industrial injuries. In this vein, an eminent law professor denied that the insurance feature was the most important point of compensation law, . . . and made a criticism touched with irony of the stress laid upon that feature by stating that it has "naturally been emphasized by laymen" . . . It is probable that the aversion of the profession at that time to the study of statutory law contributed to the attitude of indifference toward the practice of the new subject.⁴³

Total Compensation Payments. Accurate figures on the total amounts received as benefits by injured workers and their dependents are not available, but reasonably satisfactory estimates have been made. Table 58 gives estimates of cash payments made under workmen's compensation laws.

⁴² Henry D. Sayre, Address to the Insurance Law Section, Fifty-Seventh Annual Meeting of the American Bar Association, August 30, 1934

⁴³ Arthur Lenhoff, "Insurance Features of Workmen's Compensation Laws," *Cornell Law Quarterly*, 1943-1944, vol 29, p 377

There has been a steady increase in total cash benefit payments during recent years, explained largely by more injuries resulting from an increasing volume of employment and production, and also by legislative liberalization of benefits. For the year 1951 it has been estimated that the total of cash payments amounted to \$708 million. There is every reason to believe that for future years the totals will be even larger. Approximately 80 percent of total cash payments are made to disabled workers, and the remainder, in the form of monthly benefits, goes to survivors of the persons who are killed in work accidents.

TABLE 58. Estimated Cash Payments Made Under Workmen's Compensation Laws, 1940, 1942-1947 ⁴⁴
(In Thousands)

Year	Total	Disability Payments	Monthly Survivor Payments ^a
1940	\$162,000	\$130,000	\$32,000
1942	212,000	170,000	42,000
1943	227,000	182,000	45,000
1944	250,000	200,000	50,000
1945	261,000	206,000	55,000
1946	280,000	220,000	60,000
1947	330,000	275,000	55,000

^a A small but unknown amount of lump-sum payments included with monthly payments.

In addition to cash payments, substantial amounts are paid for medical care. The amount spent for medical care in recent years has been estimated at approximately \$250 million annually. Table 59 shows estimated total payments, including those for medical care, made in specified years, and breaks those totals down by type of insurance carrier making them.

Private insurance carriers normally make somewhat more than half of all benefit payments. The higher proportion of benefits paid by private carriers during the war years is explained by the fact that employers with war contracts tended to insure with such carriers. State funds, competitive and monopolistic, pay out about one-fourth of the total. The proportion paid by those who carry their own insurance is about one-fifth.

⁴⁴ *Social Security Yearbook, 1945*, p. 18, Table 11, *Social Security Bulletin*, August 1948, p. 17.

Unfortunately, there are no available estimates of the number of persons receiving these benefits and therefore nothing can be concluded from the figures as to their adequacy. But it is known that benefit scales are low compared to losses in earnings and cost of medical care, and it seems reasonably safe to say that not as much as 40 percent of the losses suffered by workers and their dependents are reimbursed. The proportion of net loss was appreciably greater, and less equitably distributed, under the older employers' liability system.

TABLE 59. Estimated Total Workmen's Compensation Payments, for Specified Years ⁴⁵
(In Millions)

	1940	1942	1943	1944	1951
Total benefit payments	\$257	\$336	\$357	\$390	\$708
Insurance losses paid, private insurance carriers	135	190	213	238	444
State fund net disbursements	73	81	82	85	167
Self-insurance payments	50	65	62	67	97

Vocational Rehabilitation. In 1920, the Federal government enacted a law to promote the vocational rehabilitation of physically disabled persons. At that time it was estimated that between 50,000 and 70,000 persons were in need of rehabilitation. Ten states had already made some attempt to cope with the growing problem, and in eight of them programs of some sort were in operation. Thirty states immediately took advantage of the Federal subsidy, but the others lagged. In 1930, there were 35 states participating, and by 1937 all but Delaware.

The Federal Act made a minimum of \$5000 annually available to each state participating, and additional grants were made on a population basis, although states were required to match these additional grants. Altogether, one million dollars of Federal money was made available annually. Few states really put their hearts into the program. At the close of 1935, 17 states appropriated more than the

⁴⁵ Adapted from Michalina M. Libman, "Workmen's Compensation Benefits in the United States, 1939, 1940," *Social Security Bulletin*, January 1942, p. 12, and subsequent issues of the *Bulletin*.

maximum amount of the Federal subsidy, seven fully matched the grants, and 21 appropriated less.

Federal funds could be used only for rehabilitation, although there were no eligibility limitations related to cause of disability. Funds could be used for artificial limbs, appliances, special training, and guidance, and follow-up visits while on a job. Retraining of unemployed persons was not, of course, a part of the program. A few states provided for the maintenance of disabled persons undergoing vocational rehabilitation, but in general the lack of maintenance was a serious deterrent to the disabled. Most of those being maintained were industrially crippled and the money came from workmen's compensation funds. In 1934, when this program was at its peak, only 8000 could be rehabilitated. Between 1920 and 1934, only a total of about 70,000 received the benefits of the program.

To strengthen and extend the program, the Congress in 1936, as part of the Social Security Act, increased the annual amount of money available by \$841,000 for 1936 and 1937, and authorized a total appropriation of \$35 million annually thereafter. The sum of \$15,000 annually is apportioned to Hawaii and the remainder, less a substantial sum to cover Federal administrative expenses, is made available to the 48 states, no state to receive less than \$20,000.

The program of rehabilitation is closely tied in with the administration of workmen's compensation. Compensation legislation is making its contribution by liberalizing provisions for medical care and by authorizing additional cash payments to workers undergoing vocational rehabilitation.

Rehabilitation of injured workers should be followed by reemployment. However, a crippled person may be an added liability to an employer in case of a second injury. If, for example, a worker with only one eye is employed and loses that eye in an accident, the employer might be charged with a total disability.

To avoid this, it is provided in nearly half of the jurisdictions that employers of partially disabled workers who are again disabled are to be assessed only the cost of the second injury. In some states a "second injury" fund exists from which the worker is paid in part. The most common source of money for these funds consists of payments made by employers in death cases where there are no dependents, usually \$500 or \$1000. In a few states, insurance carriers and the self-insured pay a percentage of the compensation or premiums paid. State contributions are rare.

The problem of rehabilitation has certainly not yet been solved, and the results to date are none too encouraging, although there is some reason to believe that in the future more consideration will be given to the problem.⁴⁶ It was difficult to break away from the common law of negligence to one compensating without regard to negligence, and it is even more difficult to develop a broad view of the compensation system as a device for reducing accidents, speeding recovery, and rehabilitating industrial cripples, as well as recouping in part the wage losses suffered.

Accident Prevention. One of the principal hopes of early students of workmen's compensation legislation was that it would lead to the prevention of industrial accidents. In some states the administration of safety legislation, including the reporting of accidents, is vested in the compensation authority, and the tendency to do this is continuing. Unless accidents are fully and promptly reported to the compensation authority, the administration of the act will suffer. No other agency would seem to have nearly as much interest in reducing accidents as the compensation authority.

Substantial progress in the reduction of accidents has taken place in the United States since 1911, and much of the reduction has come about as a result of workmen's compensation legislation, and some as a result of the administration of safety legislation by compensation authorities. It can be argued, and with reason, that even more could be done if legislatures would only vote adequate authority and funds.

In Retrospect. Workmen's compensation has been in operation now for a generation, and there are not many persons living who know from first hand experience the conditions that preceded it. This flashback is worth giving:⁴⁷

After nearly 23 years of workmen's compensation acts in these United States, I believe that this may be an opportune time to take stock, so to speak, and to find out whether we are going ahead or whether we are slipping back. This occasion carries me back to the time when we had no compensation laws in the United States. In fact, my mind goes back farther than that, to when I was a little chap 11 years of age, working in

⁴⁶ See American Management Association, *Trends in Workmen's Compensation and Employee Benefits*, pp 13-14, 19-20

⁴⁷ Joseph A Parks, in *Proceedings of the 1934 Convention of the International Association of Industrial Accident Boards and Commissions*, U.S. Department of Labor, Division of Labor Standards, p. 1

a cotton mill in England. I remember being in the mill yard, and peering through the window of the office of the mill I saw a man sitting on a stool. His hand was hanging off—there was only a piece of skin holding it in place. He was receiving no medical attention whatever. I inquired, in my boyish way, why something was not done for him, and was informed that a wagon would come for him soon and take him to the infirmary. I asked why there wasn't some way of helping him in the mill, and was told the mill did not have anything of a surgical character. By and by, a wagon came and the man was bundled off to the hospital. I was informed later that nothing would be done by the mill in the matter, that there were plenty more to take the man's place. That made a profound impression on my mind, one I have never been able to eradicate.

PART FIVE

ILLNESS AND DISABILITY

CHAPTER SEVENTEEN

THE PROBLEM OF ILLNESS AND DISABILITY

THE strength and persistency of the American movement for national compulsory health insurance are eloquent testimony to the fact that the downward trend of insecurity is not a conclusive criterion on which to base social policy. For the health of the American people is on a higher level today than ever before and it gives every promise of steadily continuing to improve. However much may be said about the inadequacy of medical care, and much can be said, it must always be borne in mind that the inadequacy results from failure of the existing system of medical care to progress as rapidly as the mass of people desire. And that in turn results largely from the failure of income to keep pace with the development of opportunities to spend that income and with the development of our social conscience.

Our doctors are better trained today than they have ever been, they have more and better medicines, equipment, and facilities to work with, including hospitals and means of transportation, and medical research in America is now equal or superior to that in any other country.¹ The development of public health agencies and programs has made notable contributions to the reduction of illness and death, as has improved knowledge of dietetics. Real income, which is a basic factor in health, is materially higher than it has ever been.

The death rate for whites, which is one index of physical well-being, fell from 17.2 per 1000 population in 1900 to 10.8 in 1940, to approximately 7 in 1947, and is still going down. Although the span

¹ Bernhard J. Stern, *American Medical Practice*, Commonwealth Fund, 1945

of life has changed but little, the average length of life has increased materially in the past 50 years. The estimated life expectancy of a white child born today is about 65 years at birth, which is about 13 years more than it was in 1900. That increase has resulted largely from prolonging the lives of infants and youths. Life expectancy for persons under 40 has increased appreciably since 1900, because of the virtual eradication or marked reduction of typhoid fever, diarrhea and enteritis, diphtheria and tuberculosis, smallpox, yellow fever, malaria, and pellagra. For those above 60, life expectancy has changed relatively little since 1900. Progress has been slow in conquering the degenerative diseases, such as cancer, diabetes, heart diseases, arthritis, rheumatic fever, peptic ulcers, hypertension, and nephritis.

Great strides have been made by medical science in combatting diseases, and some of the "killers" have been brought under a fair degree of control, so much so that the degenerative illnesses of old age are assuming relatively greater importance. Geriatrics is a field of medical practice concerned with "conditioning the declining human organism to the environment in which it has to live." Given time, it will without doubt show substantial results. There is every reason to believe that the death rate and the rate of illness will continue to go down for many years to come.

Yet despite all of the improvement that has come about, sickness is still the most persistent, serious, and uncertain hazard confronting the mass of our people. Except during periods of excessive unemployment, such as this country experienced from 1932 until 1942, illness has been the major reason why people have sought charity and relief. As yet it is possible to describe only the outlines of the major problems involved, and these outlines appear only through incomplete reports and limited studies. One student of the problem has aptly described the situation in the following words:

The data necessary for comprehensive analysis of national health problems are not available from regularly compiled records. Local, State, and Federal health agencies collect information principally on births, deaths, and a limited list of incompletely reported communicable diseases. On the frequency of accidents and disabilities resulting therefrom, only approximate estimates based on records of insurance companies, workmen's compensation commissions, and industrial and safety organizations have been available. As to the provision of medical care, records of doctors, hospitals, and health agencies lack the uniformity and centralization

necessary for statistical comparisons. Any adequate picture of care received in relation to needs can be obtained only through family reporting.²

Great care must be exercised in drawing conclusions from such fragmentary data as are available. The circumstances under which a survey was made, the persons making it, the time of the year and the localities in which it was made, and, above all, the definition of what constitutes disability, must be taken into consideration, for they all affect the results.

EXTENT OF DISABILITY

One study has given us fairly comprehensive, although far from precise, data. The United States Public Health Service sponsored the National Health Survey, which extended in time from October 1935 to the end of March 1936, covered over 700,000 urban households in 18 states, and 37,000 rural households in 3 states, and included a total of nearly 3 million persons.³ Some general findings of that survey are given in Table 60.

Numbers Disabled. It was found by the National Health Survey that 4.4 percent of the population observed were disabled on the day they were visited. All wages and all disabilities which kept a person from work, school, domestic duties, or other activities for at least one day were included. The percentage figure of 4.4 was not that of any given day, but rather that of the day of visit. Visiting days covered the winter and early spring months of 1935-1936, and it should be added that there was a mild epidemic of influenza in the spring of 1936.

Assuming that the sample covered represented conditions in the country as a whole, which then had a population of 132 million, we may say that during those winter and early spring months 5,700,000 persons were disabled on any one day. More than one-fourth of these, or 1.2 percent of the entire observed population, had been disabled for the entire 12 months preceding the day of visit. Applying the same percentages to a population of 145 million, the total

² George St. J. Perrott, Clark Tibbitts, and Rollo H. Britten, *The National Health Survey*, Public Health Reports, vol. 54, No. 37, September 15, 1939, p. 1664. See also George W. Bachman and Lewis Meriam, *The Issue of Compulsory Health Insurance*, The Brookings Institution, 1948.

³ For a detailed statement of the project, see *The National Health Survey*, loc. cit., pp. 1663-1687.

TABLE 60. Rates of Illness According to Several Measures, as Shown by the National Health Survey ⁴

Type of Information	Rate
Percentage of persons disabled on day of visit ^a	4.4
Percentage of persons disabled for the whole 12 months immediately preceding visit ^a	1.2
Percentage of persons reported as having a chronic ^b disease or impairment ^c ^d	17.7
Illnesses disabling for a week or longer during the 12 months immediately preceding the visit. ^e ^f	
Frequency per 1000 persons.	
All illnesses	171
Acute	123
Chronic ^b	48
Diseases	45
Impairments ^c	2.9
Excluding persons disabled for the whole period	159
Number of days of disability per person observed. ^g	
All illnesses	9.9
Acute	2.6
Chronic	7.3
Diseases	6.3
Impairments	1.0
Excluding persons disabled for the whole period	5.6
Number of days of disability per case ^g	
All illnesses	58
Acute	21
Chronic	154
Excluding persons disabled for the whole period	36
Percentage of workers ^h 15-64 years of age who were reported to be "unemployable" by reason of disability ⁱ	1.1

^a Based on 2,502,391 persons in 83 cities^b "Chronic" refers to illnesses the disease symptoms of which had been observed for at least 3 months before the day of visit.^c "Impairment" includes unpaired or lost members, deafness and blindness (A person may have had more than one chronic disease and/or impairment.)^d Based on 12,512 punch cards selected at random (every 200th card) from among those for 2,502,391 persons in 83 cities^e Includes some cases which had been disabled for less than one week, viz., fatal cases, confinements, and hospitalized cases^f Based on 2,350,951 persons of known age and known annual family income in 83 cities. Limited to cases and persons with certain definitions given in Public Health Reports, March 15, 1940, p. 46^g Based on cases with known duration of disability. (Those with unknown duration of disability amount to only 0.4 percent of all cases.)^h Calculated according to the formula $\frac{100D}{W+D}$ where D = number of persons in the general population who were, because of chronic disease or impairments, prevented from seeking work, and W = number of workersⁱ Sole or primary diagnoses; groups given in Public Health Reports, March 15, 1940 pp. 467-470⁴ Public Health Reports, March 15, 1940, p. 445.

would be 6,380,000, of which 1,740,000 would have been disabled for 12 months or more.

Illness is more prevalent in winter than in other seasons. A study made by the Metropolitan Life Insurance Company in the spring months of 1915-1917 showed that about 2 percent of the population canvassed were disabled. But blindness, crippling defects, mental and nervous patients in institutions, and mental defectives not in institutions were not included in the Metropolitan survey, as they were in the National Health Survey.

It is not uncommon to find the estimated number disabled today inflated to 7 million and misinterpreted as meaning that 7 million "men and women" are "too sick to work on the average working day in the year." About 30 percent of the population is under 15 years of age and about 7 percent is 65 or over. Few of these work for wages. Furthermore, about half of the population of working age consists of females and only a small percentage of these are wage earners. Still further, there is more disability in the winter months than in others, and the 4.4 percentage figure is too high as a general average. A more reasonable estimate would seem to be that approximately 3 million persons are not able to work on the average working day. Even that seems to be much too high, rather than too low, an estimate.

In addition to those completely disabled by illness, there are many others, perhaps as many as 2 percent of the population, who though not well nevertheless continue to pursue their normal activities, but usually at reduced rates of efficiency. In numbers there are, if this estimate is accurate, about 1 million who are at their employments and should not be.

It should be noted that figures showing the amount of illness existing at any given time will vary with the intensity of the investigation made. Most investigations are rather superficial. Many people in need of medical care are not aware of the fact, and even physical examinations by general practitioners would not reveal all existing disabilities. Cancer, for example, is frequently discovered only after it has developed into an advanced, if not incurable, state. Eye and ear troubles often develop without being detected in their early stages. And many have died of heart trouble who were thought to be perfectly well. Tuberculosis is now frequently detected in its early stages, but only where special examinations are made, and it is still true that a large proportion of tuberculous patients entering

sanatoriums are in advanced stages of the disease. It might be added that millions of people subscribe to religious creeds, doctrines, or tenets that do not permit, or that discourage, acceptance of the existence of sickness.

Frequency of Disability. It was found in the National Health Survey that the frequency rate for illnesses lasting 7 days or more was 171.4 per 1000 persons for all ages for a year. In a population of 145 million, this would mean a total of nearly 25 million illnesses annually, lasting for 7 days or longer. If cases of disability lasting less than 7 days were included, the frequency rate would be appreciably higher, but not so significant by reason of including many trivial cases. The frequency trend in sickness and nonoccupational injuries is said to be downward.⁵

Not everybody experiences disability during the course of any given year, yet few escape it altogether for any appreciable period of time. On the other hand, many experience more than one illness during the course of a year. Although it is impossible to predict who will be ill or for how long, it is possible to tell with some degree of accuracy what the incidence of illness will be. Data gathered by the Committee on the Costs of Medical Care indicate that for every 1,000,000 persons the incidence of illness during the course of any given year will be approximately: ⁶

470,000,	or 47 percent,	will suffer no serious illness
320,000,	or 32 percent,	will be sick once
140,000,	or 14 percent,	will be sick twice
50,000,	or 5 percent,	will be sick three times
20,000,	or 2 percent,	will be sick four or more times

⁵ In a study of the experience of sick benefit associations covering the 18-year period 1920-1938 and including 2,652,759 years of exposure for men and 238,240 for women, it was found that the frequency rate of illnesses causing disability for 8 or more consecutive days for men rose from 94.1 in the 3-year period 1921-1923 to 109.8 in the period 1927-1929, dropped to a low of 81.8 for 1933-1935, and increased again to 90.9 in 1936-1938. A similar trend existed for women. The trend is much more marked in sickness than in nonindustrial injuries. The ratio of the rate of sickness and nonindustrial injuries of women to that of men for the entire period was 1.57. For sickness alone, the ratio was 1.63. W. M. Cafafer, *The Course of Disabling Morbidity Among Industrial Workers, 1921-1938*, Public Health Reports, May 31, 1940, p. 964. Data for subsequent years show a continuation of the downward trend.

⁶ I. S. Falk, Margaret C. Klem, and Nathan Smiai, *The Incidence of Illness and the Receipt and Costs of Medical Care Among Representative Families*, University of Chicago Press, 1933, p. 15. Quoted in Senate Committee Print No. 4, 79th Cong., 2nd Sess., p. 7.

If these percentages are applied to a population of 145 million, they will give a total of 97.3 million illnesses annually. The frequency of disabilities lasting 7 days or longer is given as 171.4 per 1000. Applying this to a population of 145 million gives a total of 24,853,000. We might, with reservations, conclude that there are annually approximately 72 million cases of disability lasting less than 7 days, which is approximately 3 times as many as last 7 days or longer.

Severity Rates. It is important to know the total number of illnesses at any one time or in any one year. But many of those illnesses are not serious. More important, especially in relation to medical care or cash sickness benefit systems, is the severity of disability, i.e., the number of days lost.

Average. The average duration of disabilities lasting for 7 days or more for all illnesses and all ages per person observed in the National Health Survey was 9.9, nearly three-fourths of which resulted from chronic disabilities. The Committee on the Costs of Medical Care in periodic visits to 9000 families over a 12-month period during the years 1928–1931 found 0.73 days of disability per person annually resulting from cases disabling for less than 7 consecutive days. This could be added to the 9.9, making a total of 10.6 per person, bearing in mind, of course, that the 9.9 figure is for winter months and therefore is probably high as an overall average. Excluding persons disabled for the entire period of 12 months, the National Health Survey found that the number of days lost per person observed was 5.6, counting only disabilities lasting for 7 days or longer.

Distribution. Average duration of disability per case throws some light on the problem. But perhaps a more significant measure is the distribution of all illnesses by duration. Some notion of the distribution of disabilities by duration is given by the Committee on the Costs of Medical Care's survey of 8758 families in 18 states covering the period 1928–1931, in which each family was under observation for 12 consecutive months.⁷

The average number of days lost per person was 8.7 and per disabling illness was 14.3. More than half of those ill were, of course, disabled for only a short time. Twenty percent were disabled from one to two days; 22.3 percent from 3 to 5 days; 15.9 percent from 6

⁷ Selwyn D. Colling, *Duration of Illness from Specific Diseases Among 9000 Families*, Public Health Reports, May 17, 1940.

to 11 days; 23.9 percent from 11 to 17 days; and 17.8 percent for 18 days or more. Only 4.4 percent were disabled for more than 45 days during the 12-month period. The percentage of cases in which the sick person was in bed for one day or more was 51.1.⁸

Selective Service Data. Another indication of the nation's state of health is afforded by data relating to selective service registrants rejected as unfit for service in the armed forces. Some 16 million persons were examined, and fully half of them were found unfit for military service. About 5 million were rejected outright, 1.5 million not considered fit were nevertheless inducted and were rehabilitated by the armed services, and 1.5 million were later discharged for non-service connected mental and physical defects.

The principal causes for rejection of registrants 18 to 37 years of age at local boards and induction stations from October 1940 to May 1944, and the percentage which each represents of the total, were as follows: ⁹

Mental disease	17
Mental deficiency, including educational	14
Manifestly disqualifying defects	10
Musculoskeletal (muscles and bones)	7
Syphilis	7
Cardiovascular (heart and blood vessels)	6
Hernia	6
Neurological	5
Eyes	5
Ears	4
Tuberculosis	3
Lungs	2
Underweight and overweight	1
All others	13

The rate of recorded defects per 1000 registrants examined was high for all causes except tuberculosis, blood deficiency and infections, and parasitic diseases. Three sample studies of defects are available. One of these includes 121,966 registrants examined from November 1940 through September 1941. That sample shows that

⁸ A distribution of those bed cases by duration shows that 32.8 percent were for 1 to 2 days, 30.1 percent for 3 to 5 days, 14.1 percent for 6 to 8 days; 8.4 percent for 9 to 11 days, 7.1 percent for 12 to 17 days; 3.2 percent for 18 to 24 days, 2.5 percent for 25 to 45 days, and 1.9 percent for 46 to 365 days.

⁹ Senate Committee Print No. 4, 79th Cong., 2nd Sess., p. 5. See Bachman and Meriam, *op. cit.*, chap v, for a critical analysis of selective service rejection statistics.

the number of recorded defects per 1000 examined was: eyes, 123.5; teeth, 167.8; musculoskeletal, 113.9; and feet, 172.4. Seven other defects had rates of 50 or more.

The Army rehabilitated 1.5 million who would otherwise have been unfit for military service, including 1 million with major dental defects, more than 250,000 with impaired vision, 100,000 with syphilis, and more than 7000 with hernia. It is believed by some that two-thirds of the defects could have been prevented or rehabilitated with proper and timely medical care, and that one-sixth of them could have been remedied with relative ease.

American Medical Association representatives have argued that the findings on selective service rejections do not constitute a satisfactory index of national health, because military requirements are considerably higher than for civilian productive employment. They are of course right, although it should be added that many of the defects do affect usefulness in civilian pursuits and that many of those that do not will, unless corrected, eventually lead either to reduced efficiency or to marked expenditures for medical care.

It might be noted also that the large number of rejections did not deprive the armed forces of much needed man power. For those needs were met by calling up others who were physically fit. However, some of those called to replace rejectees were more valuable to industry than the ones rejected and as a result the war effort on the home front did suffer. It was considered necessary to discontinue granting draft deferments to premedical and pre dental students, and even the Army Specialized Training Program for such students was drastically curtailed because of the Army's need for qualified man power. Advanced training in the basic sciences was also greatly curtailed.

Chronic Disability. Special notice must be taken of chronic disability which, as acute disability is being reduced by medical science, is assuming relatively greater importance. By chronic is meant here "illnesses the disease symptoms of which had been observed at least 3 months before the day of visit."

The National Health Survey found that 17.7 percent of those observed suffered from some chronic disease or impairment. Frequency was found to be 48 per 1000 persons observed, of which 45 represented illness and 3 represented impairments. The amount of time lost on account of chronic disease and impairment was 7.3 days per person observed, which accounts for nearly three-quarters of the

total number (9.9) of days of disability per person. The number of days of disability per chronic case was found to be 154. More than half of those with chronic ailments were found to be below 45 years of age, and the rate of prevalence among young people is surprisingly high. One and two-tenths percent of those visited had been disabled for the entire 12 months preceding the visit. This group constituted nearly 25 percent of those with chronic ailments. The percentage under 45 years of age disabled for the entire 12 months was 35.3.

CAUSES OF DISABILITY

What are the causes of disabling illness? The most serious types of disability in terms of time lost are the respiratory diseases which, as a group, resulted in the loss of 1.84 days per person per year to those observed in the National Health Survey. Colds and influenza are the worst among this major group. Cardiovascular-renal diseases accounted for a loss of 1.34 days, and nervous and mental diseases for 1.02 days. These three groups were responsible for nearly half of the time lost. Three other important groups are orthopedic impairments, which accounted for 0.86 days, accidents, 0.75 days, and rheumatism and allied diseases, 0.71 days. The six groups here mentioned account for two-thirds of all time lost. Approximately two-thirds of those found disabled for the entire 12 months immediately preceding the day on which they were visited had been disabled by either cardiovascular-renal, nervous and mental, rheumatism and allied diseases, or by accidents.

Of course, something lies back of these so-called causes. Much of existing disability is the result of the wearing-out process that comes with age. That much of it is inevitable. Certainly that accounts for most of the disability among the aged, and the amount of disability attributable to age will increase as death rates among younger persons decline. There is also a personal factor in sickness which involves, for example overeating, overdrinking, and physical neglect

Unawareness of basic physical conditions must also be set down as a cause. Frequently, illnesses are not properly diagnosed by physicians, with the result that severity rates are higher than they would otherwise have been. And frequently the individuals concerned, or their parents, misinterpret symptoms and do not call for the medical treatment they really need, or do not call for it in time to prevent serious illness.

The "general social, nonwork environment," with its deficient control of disease, water, milk, housing, public sanitation and other things, accounts for much disability. The employment environment also, with its night work, long hours, low wages and consequent undernourishment, monotony, speed, fatigue, and poisonous substances, is responsible for a great deal of disability, not only through accidents and recognized occupational diseases, but through non-occupational illnesses.

The relationship of our environment to illness involves more than these "adverse" elements. Our environment is markedly gregarious—school, church, factory, office—and as such provides one of the basic conditions in the transmission of communicable diseases.

Finally, it might be added that malnutrition, which seems to be universal and which arises as much from ignorance and the desire to emulate as it does from low incomes, is one of the fundamental causes of disability.

RELATION OF DISABILITY TO CERTAIN FACTORS

The various aspects of disability are related to certain factors, such as age, occupation, urbanization, income, sex, marital status, and occupation. There exists some information which brings out with more or less clarity some of those relationships. A few of those factors will now be discussed.

Disability and Age. The relationship between age and disability is suggested by the National Health Survey data given in Table 61. Only disabilities lasting 7 days or longer are included, except for fatal cases, confinements, and hospitalized cases.

There is, beyond age 15, a direct relationship between age and the frequency of disability lasting 7 days or more. But childhood and old age are the years of many illnesses. Persons under 15 years of age experience about 31 percent and those 65 and over about 61 percent more illnesses than the average for all ages combined.

There is a striking increase in the severity of individual illnesses with increasing age—from an average of 27 days per case for persons under 15 to an average of 131 for persons 65 and over. Illnesses of those 65 and over on the average last approximately 5 times as long as for those under 15, and $2\frac{1}{4}$ times as long as the average for all ages. The average duration of disability per person for all those enumerated was 99 days, and was practically identical, 5.7 and 5.4

respectively, for the age groups under 15 and 15-24, but increased rapidly thereafter and was 36.1 for those 65 and over.

The illnesses of youth are overwhelmingly acute, and predominantly of the communicable type, while those of old age are overwhelmingly chronic, and predominantly of the "degenerative" type.

TABLE 61. Annual Frequency and Disability Rates of Illnesses Disabling for One Week or Longer, According to Age ¹⁰

Age in Years	Frequency per 1000 Persons	Days of Disability	
		Per Case	Per Person Observed
All ages	171.4	58	9.9
Under 15	224.6	27	5.7
15 - 24	128.8	42	5.4
25 - 64	149.6	69	10.5
65 and over	275.6	131	36.1

Disability and Occupation. Although detailed morbidity statistics are not yet available to make possible accurate comparisons between workers as a group and other classes, it is probable that wage earners suffer proportionately more illness than do other classes. That is strongly suggested by mortality statistics of the Metropolitan Life Insurance Company. For ages up to and including 19, death rates for insured male industrial wage earners are only slightly higher than for males for the U.S. Registration Area. But beginning with the age group 20-24, the rates begin to diverge markedly. For the ages 25-54, the rates for industrial wage earners are nearly 50 percent higher than for males in the entire registration area. Beginning with the age group 55-64, the differences are not so great, but they continue to be marked, even including the group 75 years and over.

The amount of illness among industrial workers is great. In 1943, male industrial workers lost 11.4 days and females lost 13.3 days due to sickness and injury, about 80 or 90 percent of this being due to illness, mostly common ailments it is believed. Among workers themselves, death and disability rates vary with occupation. For example,

¹⁰ The National Health Survey, *Some General Findings as to Disease, Accidents, and Impairments in Urban Areas*, Public Health Reports, March 15, 1940, p. 450. *National Health Act of 1945*, Senate Committee Print No. 4, 79th Cong., 2nd Sess., p. 3.

the Leipzig sickness fund showed that for males between the ages of 25 and 34, the average days of disability suffered by stone- and marble-cutters was 11.2 and for shop employees, salesmen, etc., only 3.6. The average for excavators was 10.8, for founders, 8.4, for joiners, 6.4, and for bakers, 5.4.

Disability in Rural Areas. The situation in rural areas and small towns is in nearly every important respect worse than that in urban areas. Most families in rural areas are in the low-income groups, and what is true about medical care for low-income groups is generally applicable to them. But in rural areas, the situation is even worse, and for all income groups. The percentage of live births unattended by a physician is at least 6 times as high as in urban areas. Maternal mortality rates are about 20 percent higher. The infant mortality rate is more than 30 percent higher. There are fewer physicians, 1 to 1295 population in 1940 as compared to 1 to 613 in most urban areas, and in general doctors are not as well trained. Hospital facilities are definitely inferior in rural areas and the same is true of the availability of trained nursing care. Medical specialists of all kinds are particularly scarce in rural areas.

In 1940 the Farm Security Administration studied 11,495 persons in 2480 farm families in 21 typically rural counties in 17 states and found that 96 percent had significant physical defects. The average number of defects was 3.5 per person, and only one out of every 100 examined was in "prime physical condition."¹¹

Selective service rejection rates were found to be higher for predominantly rural areas than for urban areas, and higher for farm workers than for others. "One special study of 18- and 19-year-olds showed the rejection rate among farm boys as 41 per 100 and among the unemployed, 38, compared with 20 per 100 among professional and semiprofessional workers, craftsmen, foremen, and kindred workers."¹²

However, death rates in rural areas are lower than in urban areas at ages 35 and above.¹³ Higher rural mortality rates below age 35 are probably accounted for by less adequate medical and public

¹¹ U S Senate, 78th Cong, 2nd Sess., *War Health and Education*, Interim Report from the Subcommittee on Wartime Health and Education to the Committee on Education and Labor, January 1945, p. 5.

¹² Senate Committee Print No. 4, 79th Cong., 2nd Sess., p. 6.

¹³ Metropolitan Life Insurance Company, *Statistical Bulletin*, vol. 29, No. 2, February 1948, pp. 5-7

health facilities. The ratio of urban to rural death rates in 1940 was 1.23 for white males and 1.12 for white females. Excess urban deaths are found for nearly all of the major causes of death, pneumonia and influenza being exceptions for both white males and females, intracranial lesions of vascular origin for white females, and homicide for white males.

Disability and Income. It has long been known that disability is more frequent and severe among low than among high-income groups. The frequency for all ages and all incomes was found in the National Health Survey to be 171.4. Among those on relief it was found to be 232, or 35 percent greater than the general average, for those in families with incomes of less than \$1000 it was 176, and 155 for those with incomes between \$1000 and \$1500. For families with incomes of \$1500 or more, the frequencies were practically identical. This latter finding may be stated as follows: in families with incomes of \$1500 or more, there appeared to be no causal relation between the amount of income and frequency of illness.

Income levels have risen markedly since 1935-1936, and the relationship between frequency of illness and the specific income levels given above does not exist at present. Furthermore, there has been a substantial increase in total income and there have been shifts in the relative distribution of income as between different groups. It is not at all clear just what the present situation is. However, one may be reasonably certain that something of the same general relationship still exists for comparable income levels.

The situation is somewhat similar when the severity of illness is considered, as data collected by the National Health Survey and given in Table 62 show. For all ages and for each age group, the duration of illness was highest among those on relief, and was next highest for the relief and the nonrelief group receiving under \$1000. Duration of disability was nearly twice as long for nonrelief persons with family incomes of less than \$1000 as for those with incomes of \$3000 or more. Low-income groups fared worse in the matter of duration than they did with respect to frequency, as compared with the higher-income groups. As with frequency, duration in the all-ages combined group was practically identical for all income groups above \$1500.

It seems strange, but is apparently true, that among children in nonrelief families the duration of illness should increase directly with higher incomes. Children of the more prosperous families un-

doubtedly receive more and better medical care than do those in less prosperous families, and presumably the duration of their illnesses should be shorter. Perhaps what actually happens is that the wealthier parents do not permit their sick children to engage in their normal activities as quickly as do the poorer parents. And most children are, of course, subject to the same contagious diseases.

TABLE 62. Days of Disability for Persons of Different Ages, According to Economic Status ¹⁴

Annual Family Income and Relief Status	All Ages	Under 15	15-24	25-64	65 and Over
All incomes	9.9	5.7	5.4	10.5	36.1
Relief	16.0	6.8	8.6	21.8	58.8
Nonrelief.					
Under \$1000	11.6	5.0	5.9	12.4	37.6
\$1000 to \$1500	7.9	5.4	4.7	8.0	30.7
1500 to 2000	6.9	5.3	4.2	6.8	26.7
2000 to 3000	6.9	5.7	3.6	6.6	27.0
3000 to 5000	6.6	5.8	3.4	6.4	22.8
5000 and over	6.9	6.3	3.1	6.0	24.6
Relief and nonrelief under \$1000	13.5	6.0	7.1	16.0	44.4

For all age groups above 15, duration decreases as income increases, almost without exception. Except for those under 15, then, duration varies inversely with income. Those on relief suffer longest from every major disease and also from accidents, and markedly so from hernia, tuberculosis, varicose veins, blindness and deafness, diabetes, diseases of female genital organs, hemorrhoids, orthopedic impairments, miscellaneous digestive diseases, and rheumatism.

The percentage of those disabled among the unemployed 15-64 years old was found to be 3.6, while among the employed it was only 1.7. The older the age group, the higher was the percentage of disabled unemployed. The percentage of persons "unemployable" by reason of disability was 1.1 for those aged 15-64, but there were 13 times as many unemployables among those on relief as there were in the group with incomes of \$5000 and over. The data do not show to what extent poverty is cause and to what extent it is effect. But no doubt it is frequently the result of illness.

¹⁴ *National Health Survey*, Public Health Reports, March 15, 1940, p. 454

Medical Care and Income. Data gathered in the National Health Survey show that the proportion of illnesses attended by physicians is higher among those with large incomes than among the poor, which merely confirms what already is commonly known. For all incomes combined, 74 percent of the cases outside hospitals were attended by a physician, and the average number of calls per case of disabling illness was 4.9. For those on relief, the percentage was 70 and the average number of calls 3.9. However, those earning \$3000 and over were attended in 83 percent of the cases and received an average of 5.7 calls per case of disabling illness.

Children do not get the attention they need. A study in 84 cities revealed that 28 percent of the children suffering illness disabling them for 7 days or more had neither the care of a physician nor hospitalization. Among children in nonrelief families with incomes of less than \$1000, the percentage was 33, while among those on relief it was 29. Here again is one of the vagaries of charity.

Data for nursing care show the same thing to an even more marked degree, with those having incomes of \$3000 and over receiving private-duty nursing in 11.6 percent of the cases as compared with averages of 3.6 for all illnesses and 1.1 percent for those on relief. The discrepancy in the proportion of hospitalized cases of illness disabling for one week or longer was not so great. Those with incomes of \$3000 and over were hospitalized in 30.4 percent of disabling cases while the overall average was 27.1 and for those on relief 26.8. It should be noted that in nonrelief families with incomes under \$1000 only 23.9 percent were hospitalized, the lowest figure for any group.

A problem also exists in the matter of hospital facilities. There were in 1938 a total of 6166 hospitals with 1,161,000 beds that were registered by the American Medical Association. Of these, 4438, or 72 percent, were nongovernmental, but 70 percent of the beds were in governmental hospitals. About 10 million patients are admitted annually into hospitals and there are at any given time about 1 million bed patients under care. Clinics and dispensaries receive about 30 million visits annually.

In 1938 there were 1338 counties with a total population of 17,000,000 which did not have a registered general hospital. These were agricultural counties with low incomes. However, it has been estimated that 98 percent of the population lives within 30 miles of a general hospital, although facilities are in many instances obso-

lete and in many areas inadequate. Most of the people not within 30 miles of a general hospital are in sparsely settled regions.¹⁵

By 1946, about 78 percent of the country's hospital bed capacity was in governmental hospitals. Government hospitals, half of them being for mental and nervous cases, accounted for 40.8 percent of total hospital admissions. Nongovernmental hospitals, with only 22 percent of the total bed capacity, accounted for about 60 percent of the admissions. Cases in government hospitals are of longer average duration than those in private hospitals. About 80 percent of the tuberculosis cases and practically all of the mental cases are cared for in government hospitals.

If states are listed in descending order of average per capita income, the highest quarter will be found to have had, in 1935-1937, 4.16 general and special allied hospital beds per 1000 population, the second fourth, 3.36, the third, 2.51, and the lowest, 1.72.¹⁶ Since disabling illness, and consequently the need for hospitalization, is greatest among the poor, this means that hospital facilities are least available where they are most needed.

Figures on the amount of hospitalization actually used bring out the same fact. The patient days of care per 1000 population, for the years 1935-1937, was for the highest fourth, 1108.7, for the second fourth, 824.3, for the third, 550.7, and for the lowest, 376.9. Furthermore, the percentage of available beds occupied is lowest in the low-income states. The percentage in 1935-1937 was 74.3 for the highest fourth, 68.7 for the third, and 63.0 for the lowest. Thus "where money is scarcest beds are fewest, and where beds are fewest they are least often used." Other factors accounting at least in part for this inverse relationship are the low quality of hospitals, inadequate means of transportation, and lack of public education in the use of hospital facilities.¹⁷

Annual per capita income received by hospitals in the wealthiest states was \$3.37, of which \$2.08 was paid by patients, \$0.82 came from taxes, and \$0.47 from other sources, mostly gifts. For the second fourth, the total was \$3.25, of which \$2.02 came from patients, \$0.77

¹⁵ Victor Johnson, *Hearings Before the Senate Committee on Education* 79th Cong., 2nd Sess., on S. 1606, Part 2, p. 702

¹⁶ E. H. Pennell, J. W. Mountin, and Kay Pearson, *Existence and Use of Hospital Facilities Among the Various States in Relation to Wealth as Expressed by Per Capita Income*, Public Health Reports, May 10, 1940, pp. 822-846

¹⁷ Victor Johnson, *Hearings Before the Senate Committee on Education and Labor*, 79th Cong., 2nd Sess., on S. 1606, Part 2, pp. 703-704

from taxes, and \$0.46 from other sources. In the third fourth, the total was \$2.15, of which \$1.62 came from patients, \$0.31 from taxes, and \$0.22 from other sources. In the poorest fourth, the total was only \$1.40, of which \$0.96 came from patients, \$0.27 from taxes, and \$0.17 from other sources. Thus the proportion of the total per capita hospital income which is paid by patients increases as the income of the patients decreases. And finally, it has been estimated that the amount paid by patients per \$1000 of state income is about the same in each group of states, being \$4.70 in the first fourth, \$4.41 in the second, \$4.64 in the third, and \$4.18 in the fourth.

The spectacular development of prepaid hospital care plans discussed elsewhere in this book, the expansion of hospital construction, and the increase of prices and incomes have materially affected the extent to which hospitals are used and the income received by hospitals.

THE COST OF DISABILITY

There is no doubt that disability imposes a heavy burden on mankind. A part of that burden can be measured by the amount of money spent for medical care, a part by the loss of income occasioned, and a part, not measurable in terms of money, in the suffering experienced.

Expenditures. The total amount of money spent for the medical care of such a tremendous volume of disability is obviously great, even though not all illness is cared for. The Committee on the Costs of Medical Care estimated that in 1929 the total annual outlay for medical care was about \$3.6 billion. Private physicians and dentists received \$1535 million, or about 43 percent of the total, private nurses \$212 million, or 6 percent, some \$656 million, or 18 percent, went to hospitals for operating expenses, \$665 million for drugs, and \$588 million went for other purposes.

The medical profession claimed at the time that it was rendering daily "free" services worth about \$1 million. The "sliding scale" of fees used by doctors suggests that some of the services to the indigent and the poor were not "free," but were paid for by the more financially able patients. There is every reason to believe, however, that the profession has always given much free service, and some of that service is of the very highest quality.

Persons with incomes of less than \$2500, most of whom were wage

earners, paid in 1929 about \$1.5 billion for medical care, which amount exceeded by about 65 percent the estimated wage loss of \$900 million. The wage loss and medical costs of workers are said to equal about 6 percent of their incomes. A worker with an income of \$1500 would, if this is true, lose on the average about \$90 annually in reduced wages and medical bills.

Before the second World War, about 75 percent of the cost of medical care was paid by patients and their families, 4 or 5 percent by employers and philanthropists, and about 20 percent by Federal, state, and local governments. The proportions have changed somewhat since then, for governments are spending relatively more for the care of low-income groups.

The average amount spent for medical care is not excessive. The trouble is that the burden is very unequally distributed among individuals, for both the frequency and severity of illness are unequal. The Metropolitan Life Insurance Company found in a study of its policy holders for the period January-June 1929 that 6 percent had no expenditures for medical care, 20 percent bore 64 percent of the total costs, and 1 percent bore 10.9 percent of the total cost. A study of 8581 families made by the Committee on the Costs of Medical Care found that 58 percent of the families had medical bills of less than \$60 per year, 32 percent had bills of \$60-\$250 per year, and 10 percent had bills of more than \$250. The first group bore 18 percent of the total outlay by these families, the second, 41 percent, and the last, 41 percent. Other studies have revealed the same general pattern of unevenness in the distribution of medical costs.

Table 63, based on data from the Division of Research, Consumer Income and Demand Branch of the Office of Price Administration, gives summary figures on income and medical care expenditures of 33.5 million families during the prosperous year of 1942. Expenditures in 1942 were higher than those shown by the Committee on the Costs of Medical Care for the first six months of 1929, but the same relationship between income and expenditures is shown. Families with incomes of more than \$5000 spent nearly 6 times as much for medical care as those with incomes of less than \$1000 and the percentage of their total income so spent was only slightly more than one-third as large.

Physicians have not, on the average, received excessive returns for their services. For 1929, their average income was estimated at \$5700 net. There is no doubt that during the long depression and

slow recovery following 1929 net income declined considerably. The war increased average income materially, for physicians as well as for nearly everybody else not in the armed forces. For 1941, it was \$5047, still below the 1929 level in absolute terms, but higher in terms of purchasing power because the general price level was about 16 percent higher in 1929 than it was in 1941. But for 1943 it was \$8688, and for 1947 it was \$9884, which represents a marked real increase. The scarcity of physicians in civilian practice during the war meant more work for those not in service.

TABLE 63. Family Expenditures for Medical Care, by Income Class, for 1942

Aggregate Money Income During 1942	Families in Each Income Group		Income Spent for Medical Care	
	Approximate Number (in Thousands)	Percentage of Total	Average Amount	Percentage of Total
Less than \$1000	6900	21	\$ 42	6 8
\$1000—\$2000	9800	29	68	4 5
\$2000—\$3000	6800	20	96	3 9
\$3000—\$5000	6700	20	143	3 7
More than \$5000	3200	10	241	2 4

Physicians in small communities get considerably smaller amounts of income than do those in large cities, as would be expected. In towns of less than 1000 population, the average net income was about \$3000 in 1941. Specialists make considerably more than general practitioners, more than twice as much in 1929, but the difference has declined considerably since 1929. There are, of course, many physicians who receive very little. In 1941, almost one out of 6 had a net income of less than \$1000, and nearly 2 out of 8 had net incomes of less than \$2000, probably because they deliberately restricted the volume of their practice. Dentists, who tend to congregate in cities, received about \$700 less net income than physicians in 1929, and about \$1200 less in 1941.

Incomes of nurses are low. In 1941, full-time private-duty nurses received about \$981 with full maintenance and \$1200 with no maintenance. Pay in Government hospitals is generally higher than in others. Public health nurses received about \$1600 in voluntary agen-

cies and \$1900 in municipal health departments. The need for the services of nurses has increased greatly since the Second World War and this, coupled with some inflation, has raised their salaries. But the pay of nurses is still comparatively low.

Loss of Income. The cost of illness and other disabilities is unquestionably high. Not only are there heavy medical expenditures, but there are losses in income as well. It was found by the Committee on the Costs of Medical Care that the annual wage loss for totally disabling illness among persons with incomes of less than \$2500 was about \$1 billion. There are more than wage losses to workers involved, however. Employers lose as a result of such things as turnover and absenteeism, and from reduced efficiency among those who continue at work though they are not well.

No good estimates of the amounts involved exist. The Federal Security Administrator testified to the effect that in 1942 illness cost American industry 4 billion workdays, which amounted to a full year's work for 13 million people. He also said: "The price we paid for sickness and disability in 1943, the wages lost by workers and the costs to business, added up to not less than \$15,000,000,000."¹⁸

This appears to be a gross exaggeration. Fifteen billion dollars is equal to approximately 10 percent of the national income in 1943. It is not true that 10 percent, or anywhere near 10 percent, of our working population was, on the average, unable to work because of disability. The total gainfully occupied was higher than it had been for years. Accessions were appreciably greater than separations, although both were abnormally high. If \$2500 is taken as average annual earnings, and 3 million workers as disabled, the total "wage loss" would be about \$7 1/2 billion.

Assuming that 4.4 percent of the labor force is disabled, a percentage which appears to be excessive, and applying that to a labor force of 45 million, the number disabled would be approximately 2 million. With average earnings of \$2500, the "wage loss" would be \$5 billion.

Both of these estimates are probably gross exaggerations. The estimated numbers disabled and the estimated average earnings used are both high. Furthermore, computing wage losses on the

¹⁸ United States Senate, *National Health Program, Hearings Before the Senate Committee on Education and Labor on S. 1606*, 79th Cong., 2nd Sess., Part 1, pp. 132-133.

basis of total number of persons of working age who are disabled involves the assumption that had they not been disabled there would have been work for them to do which no one else could do, or which they themselves could not have done later. Only in periods of full employment would this be true. It is conceded that 1943 was a year of full employment, but there are relatively few such years.

It should be noted that in some cases, as normally in coal mines, the absence of some workers is frequently of no consequence whatsoever to industry. The amount produced may not be affected at all, those reporting for work producing more units per person. In other cases, many more than commonly believed, there are available experienced persons who can step into the sick person's place at little or no extra cost to the employer. This is frequently true, for example, in packing plants and retail establishments, and is obviously true in nearly all cases involving unskilled and semiskilled workers, except in periods and places of full employment. There are cases, but they are relatively rare, where the illness of a key worker seriously disrupts the productive process.

All this leads to the conclusion that estimates of income losses resulting from disability, including those made by the author, are not to be taken too seriously. It does not, however, lead to the conclusion that those losses are insignificant.

Indirect costs to employers are even more difficult to estimate than wage losses. However, employers probably bear relatively little of that so-called indirect cost. For they tend to include it in cost of production and to pass it on to the consumer in higher prices or lower quality or reduced service.

DISABILITY INSURANCE

The rich have always fared better in medical care than the poor, at least since medicine has ceased to be mere magic; and so long as there are rich and poor the rich will continue to be better served. Under no conceivable organization of medical care will all doctors be equally able and industrious. The cream of the profession will be able to serve only a limited number, and if that limited number does not consist of the rich it will consist of the favored—the leaders of the State and Party, probably. For the masses, medical care will always and necessarily be relatively inferior. The quantity of medical care available may, however, be increased and possibly the average

quality improved. And this is vitally important. Government subsidies to those unable to purchase adequate medical care are justifiable, and indeed there are few, even among the medical profession, who deny this or who are opposed to the subsidy in principle.

The Need for Insurance. The significance of insurance for medical care, and partial compensation for lost earnings, lies not in the inevitable, although minor, redistribution of income which any social insurance system entails, nor in the improved quantity or quality of services rendered, which would be relatively negligible, nor even in the public health and preventive elements which such a system would have, at least to a minor degree.

The significance of insurance lies in the fact that it makes more uniform and certain the incidence of a financial burden which may be heavy and which cannot be predicted for any one individual. If each worker experienced only the "average" amount of disability, the burden would be of such small proportions that it could be dismissed from any further consideration, except for the very poorest. But it happens to be otherwise. The consequences of prolonged disability are serious, so much so that the general welfare will be promoted by a properly constructed and efficiently operated system of insurance. That such a system might increase the quantity and improve the quality of medical care and that it might also diminish somewhat the amount of disability are relatively unimportant considerations.

The Social Security Board, in its 1945 Annual Report, said:

The object of social insurance against medical costs is to remove a financial barrier which keeps people from getting service promptly when they need it, from getting adequate service, and sometimes from getting any service at all. Such insurance is not socialized medicine but a method of payment. The Board believes that patients should be free to choose their own doctors from among all who elect to participate in the system and to change doctors if they wish, and that doctors should be free to reject patients. There need be and should be no fear of regimentation of patients, doctors, or hospitals. Rather, with assurance that the bills will be paid from the common fund, patients will be freer to seek the care they need, and hospitals and medical practitioners will be freer to make use of the best that modern science has to offer and will have both incentive and opportunity to improve standards of medical service. Both institutions and individual practitioners would have far greater assurance than at present of steady and adequate income. This assurance will make for

better distribution of medical care resources as well as greater and better use of existing resources, though additional measures are needed to provide adequate hospital facilities in low-income areas which now lack them. The Board believes that establishment of a comprehensive system of medical care insurance need not and should not supplant many existing group arrangements for medical care for persons who may wish and be able to take advantage of additional services such arrangements can offer.

There is, to be sure, considerable difference of opinion as to whether insurance will do all of these things. In a later chapter, arguments for and against a national compulsory health insurance system will be given in some detail. But it is really significant that there is now no longer much serious opposition to the use of insurance for medical care, even in the medical profession. Many voluntary insurance systems have been devised, and the greatest expansion in numbers covered has been in plans sponsored by medical societies. Some progress has also been made in providing cash benefits for disabled persons. Such plans will be described at some length in subsequent chapters.

Insurance and Recorded Disability. It may be well to mention here that whenever a system of health insurance, whether cash or medical or both, is provided, and whether it be compulsory or voluntary, the recorded rate of disability increases. This phenomenon is quite frequently interpreted as proof that health insurance "increases sickness" or that it demoralizes those whom it is intended to benefit.

In order to understand this phenomenon, several factors must be borne in mind.¹⁹ In the first place, a health insurance system will result in a more complete enumeration of the disabled. In other words, more sick people will be counted when cash or medical benefits are available. In the second place, fewer sick people will continue at work. Medical care will be sought more frequently if it is available, and cash benefits will make it possible for some to give up their jobs temporarily. In the third place, the disability rate will generally tend to vary inversely with business conditions. In good

¹⁹ I S Falk, Barkev Sanders, and David Federman, *Disability Among Gainfully Occupied Persons*, Social Security Board, Bureau of Research and Statistics Memorandum No. 61, 1945, pp 9-10 This study is recommended to those who wish a more elaborate analysis of disability statistics than given in this chapter See also I S Falk, "Financial Aspects of Medical Care Insurance," *Social Security Bulletin*, December 1947, pp. 17-23

years, many with some impairments will nevertheless be induced to seek jobs, and there will be employers who will hire them. Furthermore, when wages are high, malingerers will be more apt to work. It is admitted by everybody that some people who are in no way disabled will get themselves on the rolls, frequently in connivance with their physicians, but it is not admitted that there will be many of them, except perhaps in times of severe depression.

The Movement for Insurance. The beginnings of voluntary sick benefit systems are irretrievably buried in the dim past. In all civilized countries, organized groups have voluntarily undertaken the task of paying benefits to their members whose earning powers have been impaired by illness. These organizations and their practices in some countries came to be subsidized by the government and welded into loose voluntary national systems, while in other countries they have provided the impetus to and the nucleus of compulsory national health insurance schemes.

In America, where the movement has only recently emerged from the beginning stage, much is owed to the foundations laid by "the Germans with their 'Krankenkassen,' the English with their strong adherence to fraternal orders, friendly societies, and trade unions, the Italians with their 'Societa' and the Jewish communities with their lodges, semi-religious and semi-charitable . . ." ²⁰ As late as 1907 we had only approximately 805 union, industrial benefit, establishment, and railroad funds having 1,130,000 members and paying out \$4,480,000. Today there are many more, but the movement is still small for so large a country.

The movement for compulsory health insurance in America was launched by the American Association for Labor Legislation in 1912, through its newly appointed Committee on Social Insurance. Jane Addams, Paul Kellogg, Edward T. Devine, Joseph Chamberlain, John B. Andrews, and I. M. Rubinow, prominent social workers and social reformers, were among the leading spirits who conceived and sustained the movement. ²¹ Workmen's compensation had by that

²⁰ I. M. Rubinow, *Social Insurance*, Henry Holt & Company, Inc., 1913, p. 283. See also Franz Goldman, *Voluntary Medical Care Insurance in the United States*, Columbia University Press, 1948, chap. 2.

²¹ This material is taken mostly from I. M. Rubinow, *The Quest for Security*, Henry Holt & Company, Inc., 1934, chap. xvii, Harry Alvin Millis, *Sickness and Insurance*, University of Chicago Press, 1937; and Pierce Williams, *The Purchase of Medical Care Through Fixed Periodic Payments*, National Bureau

time gained a foothold and was making rapid strides forward. To that group, the problem of illness seemed to be the most pressing. A slogan: "Health Insurance—the next step in social progress," was coined and announced.²² An American Conference on Social Insurance was held in 1913, the Association devoted the major part of its December 1913 meeting to health insurance, and the subject was brought before the 1914 National Conference of Charities and Corrections.

The Committee on Social Insurance drafted a "standard" bill, which was introduced in several legislatures. Eleven official state commissions on health insurance were appointed between 1915 and 1920. Discussions were promoted in all manner of conventions; local committees grew up in many and varied associations. Striking success was achieved in making American students of the social sciences "health insurance conscious." But beyond this limited circle, the movement won little support.

After a brilliant but brief period, the movement collapsed. Dr. Rubinow's discussion of the reasons for the collapse is illuminating. The war and postwar psychology was adverse—Germany, the "enemy," had health insurance and therefore it was not good for us. More important were the "mistakes" made by those in charge: "overenthusiasm, overconfidence, . . . and last but not least failure to recognize the various class and group interests involved." The opposition of various important groups, which combined into a "united front," was thoroughly aroused. Popular prejudice against "intellectuals" was played up, and proved in the long run to be detrimental to the movement.

Employers, although not as bitter and partisan as some other groups, were on the whole opposed, and in New York aggressively so, on the ground that their costs would be increased. Workers, especially union leaders, were opposed because deductions would be made from their pay envelopes. The American Federation of Labor in 1916 went on record as favoring the extension of social insurance by unions, but was opposed to compulsory state plans and to private plans for profit—a dog-in-the-manger attitude. From 1918

of Economic Research, Inc. It is reproduced with modifications from the author's chapter, "Minimum Income Insurance," in Seba Eldridge and associates, *The Development of Collective Enterprise*, University of Kansas Press, 1943

²² Lloyd-George had coined the phrase "Health Insurance."

through 1921, Federation committees studied and debated the question, but failed to agree, and interest finally died out. It should be recorded, however, that at least 11 state Federations were favorable, especially that of New York. Samuel Gompers was consistently opposed.

The medical profession was for a brief time interested in securing provisions in pending bills that would safeguard its interests, but by 1920 it was definitely opposed to any compulsory plan, and largely because it feared a reduction of income, restrictions on freedom in practice, and extra clerical work. The editor of the *Journal of the American Medical Association*, Morris Fishbein, was especially aggressive in opposition. No doubt the profession's contempt for all forms of "contract" practice, based possibly on experience in mining and lumbering camps, was also a factor. Most of those in the profession who favored insurance were teachers in medical schools, salaried physicians in industrial health departments and officials in public health institutions. Dentists, druggists, and practitioners of medical cults were allied with the physicians.

Commercial life insurance men were perhaps the most active opponents, partly because they feared the specter of "state insurance" but largely because they feared the loss of a large and lucrative business. There were in force some 44 million industrial insurance policies, amounting to about \$6 billion. It was feared that the funeral benefit proposed in health insurance plans would practically eliminate that business. "By including the funeral benefit," said Dr. Rubinow, "the health insurance movement signed its own death warrant."²³ Fraternal societies writing insurance were opposed largely for the same reason.

The ideal of health insurance did not die with the virtual collapse of this ambitious movement in 1920. Mounting protests against the cost and organization of medical care led in 1929 to the establishment of the Committee on the Costs of Medical Care, with Dr. Ray Lyman Wilbur, Secretary of the Interior, as chairman. It was thoroughly representative, adequately financed by eight foundations, and assisted by a large and able research staff. The Committee planned and carried out a five-year program of research and study, and published its findings and recommendations in some 28 publica-

²³ *The Quest for Security*, p. 213.

tions. Public interest was immediately revived with the first publication in 1932, and that interest was sharpened by the business depression existing at that time.

A majority of the Committee favored medical and hospital care insurance, on a voluntary basis until adequate experience could be developed to serve as a sound basis for compulsion. The Committee did not consider the matter of cash benefits to offset in part wage losses, as that was outside the scope of its assignment. It approved also coordinated group medical practice organized around health centers. It recommended that the cost of medical care for veterans, soldiers and sailors, the indigent, certain of the institutionalized, and the tubercular and mentally diseased should be borne by the state. And it favored government grants-in-aid to provide doctors, nurses, and hospitals in thinly populated and poor regions.

The recommendations of the Committee on the Costs of Medical Care, the Great Depression with its attendant suffering, increase in medical charity, decrease in donations to hospitals, and decline in medical revenues, the educational activities of the American Association for Labor Legislation, the American Association for Social Security and of Abraham Epstein, its executive secretary, the shift in 1935 by the American Federation of Labor from opposition to advocacy of health insurance, the National Health Survey made in 1935 and 1936, and the approval in a 1938 special session of the American Medical Association's House of Delegates of "cash indemnity plans to cover, in whole or in part, the costs of emergency or prolonged illness," revived public interest in compulsory health insurance in the United States.

Health insurance was considered by the Committee on Economic Security, but it did not propose that a system be established. The original social security bill did provide that the Social Security Board study the problem of health insurance, and report its findings and recommendations to Congress. But that simple proposal aroused so much opposition from certain groups to the whole program that the Ways and Means Committee unanimously struck the clause out of the bill. There is in the Social Security Act no reference to health insurance. The Act does, however, make it a duty of the Social Security Administration to study the most effective means of providing economic security through social insurance and to make recommendations, and research on health insurance has been carried on and recommendations made.

The Committee on Economic Security's medical advisory Board stressed the need for preventing sickness as a logical step in dealing with the risks and losses involved, and the Committee itself proposed that the Federal government appropriate money to make possible an extension of Federal, state, and local public health services. The Social Security Act did strengthen public health programs.

A determined effort to secure the enactment of a national compulsory health insurance law was made in the Seventy-ninth Congress, and it centered on the Wagner-Murray-Dingell bill. The provisions of that bill and the hearings held on it are described in some detail in subsequent chapters. The bill did not come to a vote, but the vigorous attempt to secure its enactment and the agitation engendered have had marked effects on the health insurance movement.

Hospital construction has been stimulated, a powerful impetus was given to the voluntary prepaid medical care movement and to a lesser extent to the Blue Cross hospital care movement as well. The cash disability benefit movement owes something to this agitation. And Federal aid to states for the care of medically indigent persons, through a state insurance system, is one step nearer realization. In subsequent chapters, each of these movements except hospital construction will be described in some detail.

Recently the American Medical Association conducted a vigorous campaign aimed to check what was believed to be a strong trend in favor of compulsory health insurance. The election of a conservative administration indicates that a national system is not in the offing. It is possible that some form of subsidy to private plans may be provided. If so, it most likely will be over the American Medical Association's opposition.

CHAPTER EIGHTEEN

SOME PROPOSED FEDERAL HEALTH INSURANCE PLANS

MANY attempts have been made to secure the enactment of a national health insurance law or to stimulate the enactment of state laws, and many different types of plans have been proposed. To date, all of those attempts have failed. But they have indirectly fostered the movement for insurance, and some of them, especially the Wagner-Murray-Dingell bill of 1945, have stimulated the spread of voluntary health and hospitalization insurance. The major provisions of several Federal bills are outlined below. In addition, the Taft bill offered as a substitute for compulsory health insurance is outlined because it is the bill behind which is rallied most of the opposition to a general health insurance program.

THE NATIONAL HEALTH BILL OF 1939: S. 1620

The national health bill introduced by Senator Wagner in the first session of the 76th Congress, 1939, was no doubt the first fruit of the National Health Survey, the findings of which are described in the preceding chapter, although the results of other studies were also influential. Hearings were held by a Senate subcommittee, the first Congressional hearings ever to be held on any phase of health insurance.¹

The bill was an attempt to establish a coordinated national health and welfare program and was largely the work of the Interdepartmental Committee to Coordinate Health and Welfare appointed by President Roosevelt in August of 1935. It dealt with public health, the prevention and control of disease, maternal and child health

¹ *Hearings Before a Subcommittee of the Committee on Education and Labor*, 76th Cong., 1st Sess., on S 1620, 3 parts Report No. 1139 on the bill will be found in *Senate Miscellaneous Reports*, Part 4, 76th Cong., 1st Sess.

services, the construction and maintenance of hospitals, the training of personnel, medical care insurance, and cash disability benefits. Only the last two will be treated here.

Provision for Medical Care. Title XIII of the bill related to grants-in-aid to states for medical care. The stated purpose was to enable states to "extend and improve medical care," including all services and supplies for prevention, diagnosis, and treatment, especially but not exclusively "in rural areas and among individuals suffering from severe economic distress." At that time, most rural and many industrial areas had not yet recovered from the Great Depression. The method proposed was to subsidize states having approved plans.

In determining the size of allotments to the states, it was required that consideration be given to population, the number of persons needing medical care, any special health problems confronted, and the financial resources of the state, as measured by per capita income over the most recent three-year period for which satisfactory data were available. Thus the variable-grant principle was proposed.

Federal grants were to be limited to a maximum of 50 percent of total expenditures by the poorest states and 16% percent for the wealthiest states. Furthermore, total expenditures were defined to mean only amounts not in excess of \$20 annually per individual eligible for care, and were not to include amounts spent by the states for the care of persons suffering from mental diseases or defectiveness, epilepsy, and tuberculosis, or for those receiving medical care under any other state plan subsidized by the Congress. And in no event was the Federal government obligated to pay more than the amount "planned" by it for such expenditures, but appropriations "sufficient" to carry out the purposes proposed were authorized. No special tax was proposed, it being intended that the money come out of general revenues.

Federal advisory councils made up of members of professions and agencies concerned and informed persons to advise the Social Security Board were authorized.

Grants for medical care were to be made only to those states whose plans were approved by the Federal government. Several conditions for approval were laid down in the bill. (1) The plan had to provide for financial participation by the state, but the extent of that participation was not specified, nor was the manner in which the funds should be raised. (2) The plan had to be state-wide in

coverage, or provide for yearly extensions of coverage that would result in state-wide coverage within six years. (3) Administration had to be by an approved state agency, and if that was not a state health agency, it was required to cooperate with the state health agency in administering the plan. (4) Administrative machinery had to be approved by the Social Security Board, and personnel standards on a merit basis established and maintained. Furthermore, there had to be methods of establishing and maintaining standards of medical and institutional care and payments to be made to persons and institutions rendering services. (5) There had to be an advisory council, or councils, made up of members of the professions and agencies that furnished service and of other persons informed on the need for or provision of medical care. (6) Reports as prescribed by the Social Security Board were required. (7) The plan had to provide for cooperation between the state administrative agency and any other public agency administering related services furnished under the plan, and public welfare, vocational rehabilitation, social insurance, labor, and educational agencies. There was no provision requiring cooperation with private welfare and philanthropic agencies. (8) The state agency administering the plan had to have authority to make the rules and regulations necessary to operating efficiency and economy.

This all appeared to be designed merely to provide medical care for needy persons, especially in rural and depressed areas, although the bill did not specifically limit aid to needy persons. But it was attacked by one witness on the ground that it "insidiously promotes the development of a complete system of tax-supported governmental care, thus undermining and debasing present standards of medical service."² Another witness argued that Title XIII "is a direct design for the establishment of health-insurance systems in the various states."³ On the other hand, one witness criticized the bill because it "is not a compulsory health-insurance bill; it is only a grant-in-aid in extension of medical care."⁴

Title XIV of the bill, dealing with cash disability benefits and which will be described below, laid down as one condition for approval of cash disability benefit plans the condition that states must have made available, through a plan or plans approved under this title, reasonably adequate medical services for those covered by the

² *Ibid* , Part 1, p. 321

³ *Ibid* . Part 3, p. 911

⁴ *Ibid* , Part 2, p. 599.

plan. This would seem to mean in effect compulsory state medical care systems for all those covered by the cash disability benefits, which presumably would have been most of the wage earners.

Cash Disability Benefits. Title XIV of the bill was designed to assist the states "in the development, maintenance, and administration of plans for temporary disability compensation." Grants-in-aid to states having approved plans was the method relied upon to secure enactment of laws by the states.

The cash disability benefit feature was apparently designed to cover only employees, but the title was so loosely drawn that it could be interpreted to include anybody but those in certain excepted employments.

Temporary disability compensation meant "cash benefits," which in turn was defined to mean "payments to individuals for not more than fifty-two weeks and with respect to disability not arising out of or in the course of employment." The reference to "out of or in the course of employment" was designed to eliminate payments for occupational injuries covered by workmen's compensation acts. Employment in turn was defined as any service of whatever nature by an employee for his employer, including the service of all city and traveling salesmen. But agricultural labor, domestic service in a private home, and casual labor not in the course of the employer's trade or business were not to be considered as employment.

Disability was defined as "unfitness to work by reason of injury or illness." There was no numerical limitation, for the intention was apparently to make the benefit available to any employee in employments not excepted.

States were allowed complete freedom of action in determining the kind of cash disability benefit law they wanted to enact, in regard to coverage, types of benefits, conditions of eligibility, maximum amounts and duration of benefits, contributions, and other substantive provisions. State laws could even include agriculture and domestic service and could include provision for permanent disability. However, the Federal subsidy would not have extended to benefits paid in such cases.

Certain conditions were laid down in the bill which had to be observed by states in order to get their cash disability laws approved. (1) States' laws had to be administered by a single state agency, unless the Social Security Board found that in any particular state administration through more than one agency would not be incon-

sistent with efficient administration. (2) Administrative methods, including personnel standards on a merit basis, found by the Board to be necessary for efficient administration, were also required. (3) It was specified in the conditions that there must be an impartial tribunal to which individuals whose claims for benefits were denied could appeal. (4) State laws must, according to the bill, authorize the agency administering disability compensation to cooperate with and enter into working agreements with state agencies administering unemployment and workmen's compensation, industrial hygiene, the prevention of disease, or the treatment, care, compensation, or vocational rehabilitation of sick or disabled persons. (5) Reports as prescribed by the Social Security Board were required.

However, no state disability compensation law could be approved unless that state had a plan, or plans, as indicated above under Title XIII, approved by the Board which provided reasonably adequate medical services, including preventive services, to minimize disability among those covered by the state plan. This provision would in effect have compelled the states accepting the grants-in-aid to provide not only disability compensation, but also a system of insurance for medical care, and a fairly comprehensive public health organization as well.

It should be noted that the object of the bill was to establish compensation systems for temporary disability only. Permanent disability, which seems to be becoming of increasing importance, was not included because it was thought that invalidity insurance is more appropriately attached to a retirement system. The aim was to permit retirement for permanent disability under the Federal Old-Age and Survivors Insurance system.

Federal grants-in-aid would have been made to states complying with the provisions of this title. The Federal government would have paid one-third of the total amount of cash disability compensation paid out to disabled persons not excluded by the Federal bill. In addition to this, the Federal government would have paid one-third of the costs necessary and proper for the efficient administration of the state plan. For the fiscal year ending June 30, 1940, the bill authorized the appropriation of \$10 million, and for each year thereafter "a sum sufficient to carry out the purpose" of the title. An additional appropriation of \$25,000 to the Social Security Board for administrative expenses was authorized. No special tax was levied,

as in the case of unemployment compensation, to secure the sums needed, the Federal contribution simply being made a charge on the government's general revenues.

After a state act was approved, the Board could stop payments to a state if it found that benefits had been denied to a substantial number of persons entitled to them, if the various agencies supposed to cooperate and agree failed to do so, and if the law failed through amendment or interpretation to comply substantially with the required conditions.

Hearings were held on the bill by a subcommittee of the Senate Committee on Education and Labor. The American Medical Association was bitter and uncompromising in its opposition to the bill, not especially to the cash disability feature, which in general it favored, but to other titles dealing with medical matters. How influential that opposition was it is not possible to say. But the bill was not reported out of committee.

THE CAPPER BILL: S. 3660

Senator Arthur Capper sponsored a bill in 1940, prepared by Abraham Epstein and the American Association for Social Security, which aimed at a federal-state system of health insurance.⁵ It was proposed to encourage the enactment of compulsory laws by making grants-in-aid to states with acts approved by the Social Security Board. Compliance with certain conditions, standards, and provisions laid down in the bill was required for approval.

Coverage. In scope, state acts had to apply to all employments with the exception of agricultural labor, domestic service for employers with fewer than three employees in their service, and employment by a minor regularly attending day school as a student. Those employments could be included by the states, but needed not be, and presumably certain contributions made by the Federal government would not have been made on account of any persons employed in the excepted employments. Employers subject to the premiums levied were those, including state and local governmental units, who employed one or more persons on each of 15 or more days within the calendar year. But the employee's covered did not

⁵ S. 3660, 76th Cong., 3rd Sess. No hearings were held on the bill.

include those engaged under a contract for at least one year at an annual wage in excess of \$1500 and nonmanual workers paid in excess of \$30 per week.

Premiums. Minimum premium standards to be charged by states were prescribed as shown in Table 64. Workers were divided into four classes based on their weekly rates. The weekly contribution made by the employer on behalf of his workers was to be 40 cents, regardless of wage class. Employee contributions varied directly with the wage rate, beginning with the insignificant sum of 10 cents for workers with wage rates of less than \$15 weekly, and increasing to 40 cents for those with wage rates of \$25 and over.

TABLE 64. Premium Schedule Specified in S. 3660

Wage Class	Weekly Wage Rate	Employer	Weekly Premium			Total Weekly Premium
			Employee	State	Federal	
I	Under \$15	\$0.40	\$0.10	\$0.60	\$0.30	\$1.40
II	\$15 to \$19.99	0.40	0.20	0.50	0.25	1.35
III	\$19.99 to \$24.99	0.40	0.30	0.45	0.22½	1.37½
IV	\$25 and over	0.40	0.40	0.40	0.20	1.40

The state was also expected to make a contribution to the weekly premium, varying inversely with the wage rate. For the very lowest paid, the state would have contributed 60 cents weekly, and for the best paid, 40 cents. The Federal government was to contribute one-half as much as the state, which amount was to be used exclusively for benefits, and an additional sum equal to 5 percent of the Federal contribution, to be used for administrative costs or benefits. The Federal contributions were to be made quarterly. The combined contribution for each worker in the first and last classes was \$1.40 per week, or \$72.80 per year, assuming full employment. For Class II it was \$1.35 per week, or \$70.20 for the year; and for Class III, \$1.37½ per week and \$71.50 per year.

The contributions were all to be pooled into a state-wide fund held and administered by the state. Funds were not to be sent to Washington, as is done under state unemployment compensation laws. Employers were to deduct the employees' contributions from their wages, and no agreement was to be valid whereby the em-

ployee undertook to pay any part of the employer's share. Only one premium per week was payable on behalf of any employee. Whenever a worker was employed by two employers in any calendar week, only his first employer was liable for the employer's premium and for collecting the worker's premium. However, for casual and intermittent workers, the state could make special regulations apportioning the employer's premium among the several employers by whom the worker was employed. Contributions had to be collected by the stamp system. Employers were to purchase special stamps issued for the purpose and affix or impress them upon the employee's book or card or other record.

Benefits. As in other schemes, the proposed benefits were in cash and in kind. Before being eligible for cash sickness benefits, a person must have suffered loss of working time for a waiting period of not less than five nor more than seven consecutive full calendar days.

TABLE 65. Cash Benefit Schedule Specified in S. 3660

Benefit Class	Weekly Wage Rate	Single Person	Amount of Weekly Benefit		
			With One Dependent	With Two Dependents	With Three or More Dependents
I	Under \$15	\$ 6.00	\$ 7.50	\$ 8.50	\$ 9.50
II	\$15 to \$19.99	7.50	9.50	11.00	12.50
III	\$20 to \$24.99	9.00	11.00	13.00	14.50
IV	\$25 and over	10.50	12.50	14.00	16.00

Cash Benefits. The minimum amounts to be paid in benefits are shown in Table 65. At the time the bill was drawn, wage and price levels were appreciably lower than they now are. Minimum weekly cash benefit payments are not large, as will be noted. That is quite in line with the American emphasis on benefits in kind, or medical care. The proposal to pay additional sums for dependents is in line with the most advanced European practice. When once a person's benefit had been established, it remained at that rate for one year, but if the number of his dependents changed during that time his cash benefit would have been correspondingly changed. These cash benefits were to be payable for at least 26 weeks in 52 consecutive weeks.

Not all disabled persons would have been entitled to cash benefits, even though they were covered by the plan. Any disabled person receiving money benefits provided by a workmen's compensation act could not receive cash sickness payments. Persons receiving old-age assistance, a pension or annuity provided by a Federal, state, or local law were also disqualified.

Furthermore, no covered person could receive cash benefits unless he had made from 20 to 25 premium payments within the 52 consecutive weeks preceding the day on which he claimed cash benefits, or, as an alternative, from 32 to 40 payments within 104 consecutive weeks.

Cash maternity benefits equal in amount to the woman's sickness benefit for six weeks prior to and six weeks after birth were provided. However, no such cash benefit was payable for any week within that period during which the woman was gainfully employed. To qualify, a woman must have paid from 50 to 60 premiums within the two years preceding the day on which the benefits were to begin. Weekly maternity benefits did not affect in any way a woman's right to the sickness benefits, although she was not eligible to receive both at the same time.

A special lump-sum maternity benefit of from \$15 to \$25 had to be paid to any woman who had observed prenatal regulations established by the state, provided: (1) she was herself entitled to the regular maternity benefit; or (2) was the wife of an insured man qualified for benefits; or (3) was the widow of a man so qualified at the time of his death, if the child was born within ten months of his death. Maternity cash and medical benefits were so far as possible to be kept separate from all others and administered by public officers who were duly licensed physicians.

Medical Benefits. Minimum medical care benefits that must be provided were carefully specified in the bill. Dependents of insured persons were also to be eligible for them. There could be a qualifying requirement of not to exceed four premiums in the three calendar months preceding the day on which medical benefits were to commence, but a qualified person was entitled to medical care immediately on the occurrence of sickness or injury, provided the person was not entitled to treatment for that disability under a workmen's compensation act or some other law.

Medical care benefits had to consist of not less than the following. The services of a general medical practitioner, who could be prac-

ting as a member of a group. These services could be rendered at the doctor's office, in the home, hospital, or elsewhere, and could be preventive, diagnostic, or therapeutic, and were to include such immunizations and periodic physical examinations as the state prescribed. Medical benefits had to include, on the prescription of a doctor, necessary hospital treatment and care, the services of a surgeon or other specialist, x-ray examinations, and laboratory and clinical services. Nursing care at home or in a hospital had to be provided. Prenatal, maternity, and postnatal care at home or in a hospital were also required. Lastly, dental services necessary for the relief of pain through surgical intervention were required.

The specific amounts of these benefits which were to be provided were not set down in the bill. They were in the end to be determined by the amount of money available. One-fourth of the money paid into the plan, plus interest on unexpended balances, was to be set aside to pay cash sickness and cash maternity benefits and the cost of administering them. Three-fourths, plus interest, was to be spent for medical benefits and the cost of administering them.

Should the funds have been insufficient to provide all the different kinds of benefits listed above in adequate quantities, the state was authorized to limit the number and amount of benefits to be paid. But limits were set to the reductions that could be made. The services of a general practitioner could be limited to a maximum of 26 weeks in any one year, and the services of a surgeon or specialist and x-ray, laboratory, and clinical services to a maximum of 12 weeks. Hospital care could be limited in connection with any one illness to a maximum of 111 days, of which the first 21 had to be without charge and the remainder could be charged for at not more than 15 percent of the cost. For persons 65 years of age and over, hospitalization did not need to be furnished for more than 90 days in any 104 consecutive weeks. Unemployed persons and those ceasing to be in employment covered by the act could have their right to the services of a general practitioner or specialist, and x-rays, etc., limited to a period of 26 weeks.

Such were the minimum benefits that had to be provided and the limitations on them that could be introduced by states. Additional benefits could be furnished by the plans, either at their expense or at the expense of the patients and the plans.

Elective Coverage. There was provision for voluntary medical care insurance by persons who were not compulsorily included. Not

all such could insure, however, and those who could had to pass a health examination, as did their dependents, who would have been included. But no one who within the three preceding years had to his credit at least 52 premiums, whether paid voluntarily or while in covered employment, was required to pass a physical examination. Nor were his dependents.

Those eligible for voluntary coverage were: (1) Any resident with a total net income of \$30 or less a week and who was under 65 years of age; (2) Any resident who within the three preceding years had been compulsorily insured and had made not less than 52 premium payments and whose total net income was not more than \$50 per week; (3) Any resident with at least 52 premiums in the preceding three years who was unemployed, able to work, and available for work. All of these were required to pay a premium equal to three-fourths of the combined employer's and employee's premiums for their wage class. (4) A final class consisted of any resident who was receiving old-age or unemployment benefits or relief from government, provided the state paid on his behalf premiums which were supposed to be such as would equitably rate the risk and distribute the cost. The state had to pay into the fund for each voluntarily insured person a sum equal to three-fourths of the state's premium for compulsorily insured persons.

Administration. Machinery for administering the plan was outlined. There had to be a central state board composed of the state commissioner of health or other officer performing those duties, 11 to 15 members appointed by the governor to represent employers, employees, the medical professions, and hospitals, and the Commissioner of Health Insurance, who was a new official selected to head up the administration. This board was not to serve in an administrative or executive capacity, but was to serve as a regulatory, policy-making, supervisory and advisory body, and was to have power to establish standards for the administration of the act.

The chief administrative and executive officer was to be the Commissioner of Health Insurance. The manner of his selection was not specified.

For efficiency of administration, the state was to be divided into as many local areas as were found to be necessary. In each of those local areas there was to be a finance manager, and a full-time medical manager who was to be a physician, both serving full-time and receiving annual salaries. In each area there was also to be a local

council appointed by the state Commissioner of Health Insurance and composed of one representative of each of the professions furnishing medical benefits, employers, employees, and hospitals, and the local medical, finance, and public health officers. The local finance manager was to serve as chairman.

The local council was charged with the duty of supervising the collection of premiums, the payment of cash sickness and maternity benefits, and the dispensation of medical benefits. It was required to prepare and publish lists of practitioners and agencies within its area who were participating in the plan, and to distribute among them on a pro-rata basis those of the insured who had failed to select, or had been refused by, an agency or a practitioner. It was also responsible for maintaining the records needed in carrying out these functions. The states were permitted to impose such additional duties on the local council as they considered necessary. There also had to be in each area one or more local advisory committees representing the parties concerned.

All persons in the administration, except members of the state board, the State Commissioner of Health, and representatives on local boards, had to be selected on a merit basis through open examinations not inferior to the standards set for the United States Civil Service.

Every doctor and dentist who was licensed to practice in the state, no matter of what kind, and whether practicing independently or as a member of a group, was eligible to practice under the insurance plan, subject to removal for cause. Every insured person could select from among the list drawn up by the local council the doctor by whom he wished to be attended in case of illness, subject to acceptance by that doctor. Persons not making a choice or who were refused by the doctor were to be divided among the doctors on a pro-rata basis. The right to change doctors or reject patients was given, but subject to such notice as the state agency prescribed. Provision was required for paying cash benefits and sums equivalent to medical benefits to insured persons who were still eligible to receive them but who were no longer residents of the state.

The manner in which those rendering medical and institutional services were paid was to be determined by the local council, but no method of paying doctors could be adopted to which a majority of the practitioners in the area did not consent. Any one of several specified methods was permissible. The two simplest were a salary

system or payment on a per capita insured person basis. A fee system in which payment to individual practitioners was based on the nature and amount of treatment given was permitted. Any combination of these methods would have been acceptable. Special arrangements could be made for paying doctors or other professional persons practicing as a group.

Machinery was to be provided to hear complaints and resolve controversies. A local public officer employed on a salaried basis was the court of first instance. There also had to be independent referees under control of the state who were required to hear any complaint. From local referees, appeal could be taken to a state Appeal Board, which was to be independent of the state agency which administered the act.

If illness or injury for which benefits were paid was incurred under circumstances which created a claim for damages or compensation against another person, then the insurance fund was entitled to be reimbursed from any money received by the insured from that source, and the fund could itself take legal action to recover from the liable person.

Continual general supervision over state plans was secured by providing that if the Social Security Board, after giving reasonable notice and opportunity to be heard, found that the benefits or administration of the state plan were not in conformity to the Federal Act, then Federal contributions would be discontinued.

The bill was not pressed and did not come to a vote. For one thing, the time was not ripe. For another thing, the bill was not right. From the political point of view, a major defect was the attempt to impose basic minimum standards in altogether too much detail.

THE WAGNER-MURRAY-DINGELL BILL: S. 1606

The Wagner-Murray-Dingell Bill, introduced in the Senate on November 19, 1945, marks the peak of the recent movement to establish a compulsory national health insurance system. Title I of that bill related to grants for public health services, crippled children, maternal and child welfare services, and medical care for needy persons. It will not be treated here. Title II proposed a system of personal health service benefits, the major provisions of which are outlined below.

Coverage. A broad view was taken in the bill of what should constitute covered employment. Any service whatsoever performed within the United States by employees for employers, irrespective of the citizenship or residence of either employer or employee, under a contract of service entered into within the United States, or in connection with an American vessel or civilian aircraft touching at a U.S. port if the employees worked on it when outside the U.S., was covered unless specifically excluded. The principal exclusions were as follows:

1. Service for the United States, state, and local and foreign governments, and for their wholly owned instrumentalities, except that hourly paid labor for the Tennessee Valley Authority was specifically included. Excluded also was any service performed for an instrumentality wholly owned by a foreign government if it was similar to comparable service performed for U.S. instrumentalities in foreign countries or if the foreign government concerned exempted that service.

2. Service covered by the Railroad Retirement Act was not included, partly because special provision had been made for that industry, and partly because railroad workers would have wanted a special system for themselves.

3. Service for organizations exempt from taxation under section 101 of the Internal Revenue Code. These are mainly nonprofit labor, agricultural, religious, charitable, educational, civic, business, recreational organizations; mutual savings banks, cemeteries, and coöperatives; federally incorporated organizations exempt from Federal income taxes, religious or apostolic associations, and voluntary employees' benefit associations.

Service for these was exempt for any calendar quarter in which pay did not exceed \$45, or where the service was in connection with the collection of dues or premiums and was performed away from the home office or was ritualistic service; or where the service was performed by a student regularly attending classes.

4. Service performed by a duly ordained, commissioned, or licensed minister in the regular exercise of his ministry and service performed by regular members of religious orders in the exercise of duties required by such orders.

5. Casual labor not in the course of the employer's trade or business.

6. Service in connection with a foreign vessel if the employee worked on or in connection with that vessel when outside the United States.

Benefits. The bill proposed seven "Personal Health Service Benefits," which may be described briefly as follows:

1. The General Medical Benefit was to consist of the services furnished by a "legally qualified" physician or group of physicians, including all the necessary services usually furnished by a general or family practitioner, in the office, home, hospital, or elsewhere. It included diagnostic, preventive, and therapeutic treatment and care, and periodical physical examinations.

2. The Special Medical Benefit was to consist of the services of a specialist or consultant. It included all necessary specialist services in the office, home, hospital, or elsewhere, and could be furnished by a legally qualified physician or by a group of them.

3. The General Dental Benefit was to consist of all the necessary dental services that can be furnished by a dentist engaged in general practice, including the services of an assistant or hygienist. It included preventive, diagnostic, and therapeutic treatment, care and advice, and periodic examinations.

4. The Special Dental Benefit was to consist of the services of a dental specialist or consultant, or group of specialists, or group of general dentists and dental specialists, in the office, hospital, or elsewhere, as well as the services of an assistant, hygienist, or anesthetist under the doctor's direction.

5. The Home Nursing Benefit was to consist of nursing care in the home by:

- (a) A registered professional nurse, or
- (b) A practical nurse. A practical nurse had to be legally qualified by the state, or if there were no state standards or requirements then one who met the standards established by the Surgeon General after consultation with the Advisory Council and with competent professional nursing agencies.

6. The Laboratory Benefit was to consist of such necessary laboratory or related services, supplies, or commodities as the Surgeon General determined, and was to include:

- (a) Chemical, bacteriological, pathological, therapeutic x-ray, and related laboratory services.

- (b) Refractions and other ophthalmic services furnished by a legally qualified practitioner other than a physician.
- (c) Physiotherapy.
- (d) Special appliances prescribed by a physician.
- (e) Eyeglasses prescribed by a physician or other legally qualified practitioner.

7. The Hospitalization Benefit:

(a) Provided up to 30 days of hospitalization for which the system would pay from \$3 to \$7 per day, and hospitalization on beyond that for which the system would pay from \$1.50 to \$4.50 per day.

(b) For the chronically ill, care in an institution, for which the system would pay from \$1 50 to \$4 50 per day.

(c) Hospitalization was provided in wards or other least expensive services. Patients could use more expensive accommodations and pay the difference out of their own funds.

Limitations on Benefits. Four types of benefit limitations were provided, one of them to prevent abuses and the others to allocate inadequate medical care resources

1. *To Prevent Abuses.* The Surgeon General could determine that for any calendar year or for any part of a calendar year all individuals entitled to the general medical, general dental, or home nursing benefits could be required by their physician, dentist, or nurse to pay a fee for the first service or for all services in a course of treatment.

This rule could not be applied to selected individuals or to groups of individuals only who were in fact abusing their privileges, but if applied at all had to be made universal, although not necessarily to all three of the benefits at the same time. But this was to be done only after "good and sufficient evidence" indicated clearly that the rule was considered "necessary and desirable to prevent abuses of entitlement" for any of the benefits provided. The Surgeon General was to fix the maximum size of the fee that could be charged under such circumstances at an amount considered adequate to prevent or reduce the abuses, but that at the same time would not substantially reduce the amount of proper and needed care received by those needing it. Fees could be limited to only home calls, to only office visits, or to both, and the limitation could set a maximum amount that might be charged in the course of any one period of sickness or

treatment. Variations in fees and maximums as between states or communities, and as between rural and urban areas, were permissible.

2. *To Ration Scarce Services.* Because there were not enough specialists to provide all the necessary and proper services needed, the Surgeon General could for any calendar year or part of a calendar year limit the amount of specialist services that would be provided under the system.

General and special dental benefits could be limited according to age, if that was considered necessary and desirable. The home nursing benefit could be limited to part-time care on an hourly or visit basis, or by type of case, by maximum amount of service per case, or otherwise.

However, after the system had been in operation for a specified period of time, which was set at three months after the act was to become effective, then a minimum amount of specialist services had to be made available, including at least (a) examination (including x-ray survey) and diagnosis; (b) prophylaxis; (c) extraction of teeth considered by dentist and physician to be, or likely to become, injurious to general health; and (d) treatment of acute diseases of the teeth, their supporting structures, and adjacent parts, including fractures of the teeth and jaws. Any restriction placed on dental or home nursing benefits had to be reduced or withdrawn as rapidly as practicable.

3. *To Limit Expenditures.* The total amount of hospitalization provided was initially limited to a maximum of 60 days in any benefit year. However, when the Surgeon General found that sufficient money was available, the period of hospitalization could be extended to a maximum of 120 days for the subsequent year, or the amount paid on account of hospitalization could be increased, or both of these could be done. Application for a hospitalization benefit, to be valid, had to be filed within 90 days of the day of hospitalization.

If income, or prospective income, appeared to be inadequate, the laboratory benefit could be limited by class of services, supplies, or commodities provided, or with respect to the maximum amount that would be paid on account of any one beneficiary per year, or to a specified fraction of the cost, or a combination of these limits could be imposed.

4. *To Integrate Hospitalization and Medical Care.* In order to integrate hospitalization under the system into the general pattern of medical care, it was provided that hospitalization for tuberculosis or for a psychosis must be limited to a maximum of 30 days after the date of the diagnosis, and that no hospitalization benefit was payable for care in a hospital or institution for mental or nervous diseases or for tuberculosis.

Eligibility for Benefits. Three groups of persons were eligible for Personal Health Benefits: the "currently" insured, dependents of currently insured; and retired and survivor beneficiaries of the Federal Old-Age and Survivors Insurance system

1. To be currently insured, a person must either: (a) have been paid wages in covered employment of not less than \$150 in his "eligibility period," which meant in the first four of the last six completed calendar quarters, or (b) have been paid at least \$50 for each of not less than six of the first 12 of the last 14 completed calendar quarters—both preceding the first day of the benefit year. A worker paid \$3600 in a calendar year was automatically credited with each quarter in that year after his first quarter of coverage. The benefit year in turn consisted of four consecutive calendar quarters as determined by the administrative agency. In determining eligibility, no quarter was to be counted if at any time during that quarter a person was suffering from a disability which had lasted six months or more.

2. A dependent was defined as an unmarried child, including step-, adopted, or foster, under 18 years of age or chronically disabled; or a wife; or a chronically disabled husband, who was living with or being regularly supported by a currently insured individual; or a parent living with or receiving regular and substantial support from a currently insured individual.

3. Any person entitled to a monthly benefit under the Federal Old-Age and Survivors Insurance system, even if for only one month, was to be entitled to personal health service benefits for the entire benefit year.

Personal health service benefits were not intended to supplant the medical, dental, home nursing, laboratory, or hospitalization benefits provided by Federal and state workmen's compensation laws. If an individual who was suffering from an injury, disease, or disability for which medical care was provided under a workmen's

compensation law received personal health service benefits on account of that injury, disease, or disability, then the Surgeon General was subrogated the disabled person's right to collect the estimated cost of furnishing that service from the responsible person or agency.

However, if Federal or state or local governments wished to do so and reached agreements with the Surgeon General, medical and hospital care for their own employees or for workers covered by workmen's compensation laws could be provided through this program and could be in lieu of the medical benefits provided under the workmen's compensation acts. Benefits to such persons had to be, as far as was practicable, of the same quality, furnished by the same methods, and paid for through the same arrangements as for other individuals in the system.

Groups for which the Congress made provision, including needy persons given aid by states for which Federal grants-in-aid were made, could be brought under this insurance arrangement, and money appropriated by the Congress for their assistance, or for the administration of assistance, could be used to pay the cost of their participation. In another section of the bill, special provision was made for subsidizing approved state plans for the medical care of needy persons.

Policies. Certain administrative methods and policies to be followed were laid down in the bill.

1. Any physician, dentist, or nurse who was legally qualified by a state to practice had to be permitted to participate.

2. Standards for determining what constituted specialist and consultant services and who qualified as specialists and consultants were to be designated by the Surgeon General after consultation with the Advisory Council, utilizing in so far as possible standards and certifications developed by competent professional agencies, and taking into account the personnel resources and needs of different regions and local areas.

3. Specialist and consultant services were ordinarily to be available on the recommendation of a family physician, specialist, or consultant attending the patient. Home nursing was to be available only if recommended by the attending physician. Both were also to be available without a physician's recommendation if requested by the individual and approved by a medical officer designated by the Surgeon General.

4. Methods of administration and payment had to insure prompt and efficient care of individuals, promote personal relationships between physician and patient, provide professional and financial incentives for the advancement of practitioners, encourage high standards of care and coordination among all of the elements, aid in preventing disease, disability, and premature death, and insure adequate service as economically as was consistent with high standards of quality.

5. General medical and dental practitioners were to be paid on a fee-for-service, per capita, whole- or part-time salary basis, or on a combination or modification of these bases, as determined by a majority of the practitioners in a local area and approved by the Surgeon General. However, the Surgeon General could arrange to pay any doctor on any one of these bases if he thought it desirable, irrespective of what the majority had decided. Specialists and consultants presented a different problem. They could be paid on any one of the bases mentioned above or on a salary basis, as the Surgeon General and specialists might agree. And the Surgeon General could contract or agree with hospitals for the inclusive utilization of their facilities, their staffs, and attending staffs.

6. Rates of pay could be nationally uniform or adapted to regional, local, or other factors. Payment had to be commensurate with skill, experience, and responsibility, and adequate by reference to customary annual incomes received by practitioners.

7. Maximum limits on the number of potential beneficiaries that any one practitioner or a group of practitioners undertook to service could be imposed by the Surgeon General, and these could be nationally uniform limitations or on a local basis. The purpose of this limitation was to safeguard the quality of medical care.

8. In local areas where payment to a general or family practitioner was on a per capita basis, the per capita payments for insured persons who did not select a practitioner were to be prorated among the practitioners participating.

9. General medical and general dental benefits in local areas were the collective responsibility of general medical and dental practitioners in those areas, including the care of those who did not elect a physician or dentist.

Administration. The Surgeon General, acting under the supervision and direction of the Federal Security Administrator, and after

consultation with an Advisory Council, was charged with the administration of the plan. He was "to arrange for the availability of the benefits provided" by the bill. He was also charged with the duty of studying available methods of providing personal health and recommending legislation concerning health and related problems. Adequate personnel was to be appointed in the Public Health Service to administer the act, and existing personnel and commissioned medical officers in the regular or reserve Medical Corps of the Public Health Service could be assigned to the duty of administering the program.

It was not intended that the Federal government establish and operate the machinery for a centralized administration of the benefits provided. On the contrary, every possible use was to be made of other organizations and associations, public and private. The Surgeon General was authorized to negotiate agreements and coöperative working arrangements with appropriate agencies and institutions, and with private persons or groups of persons, or with combinations of these, for the use of their services and facilities, for which he was to pay "fair, reasonable, and equitable compensation." The Surgeon General was also to negotiate agreements or coöperative working arrangements for the purchase of necessary supplies, services, and facilities. In so far as practicable, priority and preference was to be given to state and local governmental agencies. All necessary powers and duties could be delegated by the Surgeon General to Public Health Officers, Federal, state, and local employees or agencies, as might be necessary to effective operations, except the power to make rules and regulations, which had to be retained by the Surgeon General.

The Surgeon General was to prescribe the rules, regulations, records and reports necessary for the efficient administration of the system. Before doing so, he was required to consult with the Advisory Council as to questions of general policy and administration. But rules and regulations that applied to the operations of Federal, state, or local government units could be made only after consultation with those governmental units.

National Advisory Council. A National Advisory Medical Policy Council was to be established, to consist of the Surgeon General, who was to serve as Chairman, and 16 others appointed by the Surgeon General, with the approval of the Federal Security Administrator, selected from panels of names submitted by professional

medical and medical educational agencies concerned, with a fair representation of the public. Two meetings a year were required, and others had to be called when requested by at least four members. Membership was to be for a period of four years, with overlapping terms. Pay was on a *per diem* and expenses basis.

The Council was to advise the Surgeon General on questions of general policy and administration, including. (1) professional standards of quality to apply to personal health service benefits; (2) designation of specialists and consultants, (3) methods and arrangements to stimulate and encourage high standards through coordination of all elements in the system; (4) hospital standards and coordination of hospitals, (5) methods of paying for personal health service benefits; (6) studies and surveys; and (7) grants-in-aid for professional education and research projects. The Council was to establish local committees or commissions to advise on questions concerning subjects and questions affecting regions or localities.

Local Area Committees. To assist in making benefits available and in carrying out the provisions of the act, local area committees were to be appointed. They were to be made up of persons from medical and other professions concerned, and public representatives informed of the need for the benefits provided. The professional representatives were to be selected from panels of names submitted by the professional organizations concerned.

For areas in which state or local government agencies or departments administered the benefits, the committees were to be appointed by the state or local units. For areas where private organizations were administering the benefits, the committees were to be appointed by the Surgeon General.

These committees were to be consulted frequently, and to be kept advised by local area Public Health Service Officers of the policies and arrangements made with respect to the operation of the system. They were authorized to make annual reports and such recommendations as they might care to make.

Hospitals. Hospitals that wished to participate in the program were required to meet minimum standards prescribed by the Surgeon General. To qualify, a hospital was required to provide all "necessary and customary" services and the Surgeon General had to find that professional personnel, adequate facilities, and accounting procedures existed which made possible the reports required. Hos-

pitals could be accredited for the care of limited varieties of cases if they met the standards necessary to serve adequately those cases, the type and size of community being considered.

Any hospital not admitted to participation, or one that had withdrawn, would on its petition be given a hearing. But the Surgeon General was not given any power to supervise or control a hospital not owned or leased and operated by the United States, and no requirement or condition for participation could prescribe a hospital's administration, personnel, or operation.

Appeal, Review, and Limitations. "Necessary and sufficient" appeal bodies were to be established by the Surgeon General to hear complaints from individuals, practitioners, and hospitals. Those bodies were to make findings, conclusions, and recommendations to the Surgeon General, who was to consider them in remedying grounds for complaints. Similar appeal bodies were to be established to hear and determine complaints among practitioners and/or hospitals. The Social Security Board was given the right to decide disputed rights of individuals to the benefits provided. In disputes involving professional practice or conduct, it was required that the appeal body include competent and disinterested professional representatives; and in disputes involving only questions of professional practice or conduct, the body had to consist exclusively of professional persons. Decisions made by appropriate authorities were to be reviewable in the Federal courts.

Taxes. In the bill providing personal health service benefits, there was no reference to the taxes needed to raise the necessary revenue. A separate bill was prepared for the purpose of raising revenue. It was proposed to levy a tax of 1.5 percent of wages and salaries, not counting amounts in excess of \$3600 per year on covered employers and employees, or a total of 3 percent. If dependents were to be included, as the Wagner-Murray-Dingell bill proposed, the cost would have been 3.5 percent. The total number covered would have been between 105 million and 112 million, and the total cost would have been about \$3.5 billion per year to begin with. As benefits were increased, the cost also would have increased. The ultimate cost would obviously have depended upon what benefits were provided, but a total of \$4 billion would have been reached within a very few years.

The bill did propose the creation of a Personal Health Account in

the United States Treasury and authorize appropriations to it of "such sums as may be required" to finance the system. But it was intended that the tax would supply the necessary funds. From the appropriations made, the Secretary of the Treasury was to credit quarterly to the Account amounts equivalent to 3 percent of covered wages. Annually the Secretary was to credit the estimated amount spent during the preceding year for general and special dental and home nursing benefits, and quarterly the estimated administrative costs. Only the amounts credited to the Account were to be available for benefits and administrative expenses.

S. 1320

The Wagner-Murray-Dingell bill was not enacted into law. It was reintroduced in the 80th Congress on May 20, 1947, under different sponsorship and with many modifications, some of which were drastic. The three major modifications relate to coverage and administration and state plans.

Coverage. Coverage was extended to include the self-employed, business and professional men, and farmers, agricultural and domestic workers, and Federal civil service employees. This would add to the coverage more than 15 million persons and their dependents.

Administration. Proposed administrative machinery was drastically modified. A National Health Insurance Board was proposed to have general supervision, with the Surgeon General and the Commissioner of Social Security as ex-officio members and three others, one to be a doctor of medicine, appointed by the President, and subject to the supervision of the Federal Security Administrator. The Board's functions are to approve or disapprove state health insurance plans, to administer benefits where states do not have an approved plan, to establish regulations and standards, and to assist states in devising and administering plans. It is to be assisted by an Advisory Council made up of representatives of persons eligible to benefits and personnel providing services.

State Plans. It is declared to be the intent of Congress that, wherever possible, benefits be administered by the states under approved plans, using groups such as voluntary health and hospital associations, medical societies, and clinics. States which wish to do

so are permitted to establish machinery for providing the benefits and to make agreements with voluntary health and hospital groups. Should any state be unwilling to participate, the Board will administer the act in that state.

In order to be approved, a state plan must be administered through a single state agency, must have a state Advisory Committee with a majority representing those eligible for benefits, satisfactory administrative methods, including civil service personnel. It must also make for maximum utilization of participating health personnel and facilities and make benefits available in all local health service areas. Federal funds must be properly safeguarded and expended. Provision must be made for cooperation with other public agencies. And there must be decentralized administration of the benefits provided.

Federal funds are to be allocated to states mostly on the basis of covered population, participating personnel and facilities, and the "cost of reasonable and equitable compensation for such personnel and facilities," and the cost of necessary supplies. Five percent of Federal funds are to be allocated on the above considerations plus the extent to which previous allotments have been insufficient. Emergency allotments may be made in cases of disasters or epidemics.

In so far as possible, administration of benefits is to be on the local or area level, with as little state and Federal interference as possible. The state is to be subdivided into health-service areas, each one headed by a local administrative officer or a local administrative committee with an executive officer. This officer or committee would publish a roster of participating personnel, adjust complaints, pay participating personnel and facilities, act as liaison with professional personnel, and publicize the system. It would be assisted by a local area committee of insured and service personnel and by a committee of the professional personnel. No individual or group may be given the exclusive right to provide services or facilities.

Special consideration may be given to rural areas. This may consist of a special method of paying practitioners, such as guaranteeing an annual minimum income, the payment of transportation expenses incurred by service personnel, loans for office equipment, and ambulance service. The object of this is to insure adequate medical personnel in rural areas.

THE NATIONAL HEALTH BILL OF 1947: S. 545

Opponents of the Wagner-Murray-Dingell bill, although successful in the fight against it, were thoroughly aroused by the growing strength of the movement for compulsory health insurance. They were mindful of the adverse effects on public opinion of mere opposition. But they were also concerned, many of them, with the admitted inadequacy of medical care for persons with low incomes or with none at all.

Senator Robert A. Taft combined with Senators H. Alexander Smith of New Jersey, Joseph H. Ball of Minnesota, and Forrest C. Donnell of Missouri, all members of the Committee on Labor and Public Welfare, to introduce and advocate a bill to coordinate Federal health activities in a single agency, to modify and expand the Public Health Service, to promote and encourage medical and dental research, to subsidize state and local plans for furnishing medical and dental care to the medically indigent, and for other purposes.⁶

The Taft bill as a whole will not be described here, but only those portions of it dealing with the provision of medical and dental care to the medically indigent.

Medical Services for Persons with Low Incomes. Provision is made in the bill to encourage the development of plans for medical services to families and individuals with low incomes, and for periodical medical examinations of all school children. The method used consists of grants-in-aid to states having approved plans. A total of \$200 million is authorized for each year of operation, to be distributed among the states with approved plans, and it was understood by the sponsors that more would be needed later. Administration is vested in the Director of the Office of Medical and Hospital Care Services, a proposed unit in a proposed National Health Agency. The Director must consult with a National Medical Care Council consisting of the Director as Chairman and eight members, five of whom are to be persons outstanding in the field of medical and hospital care, four of the five being doctors of medicine, and three persons familiar with the needs for medical and hospital care in rural and urban areas. There is to be no Federal supervision or con-

⁶ S. 545, 80th Cong., 1st Sess. Hearings were held on S. 545 and S. 1320, the modified version of the Wagner-Murray-Dingell bill, by a subcommittee of the Committee on Labor and Public Welfare.

trol over the administration, personnel, maintenance, or operation of state medical care plans.

The proportion of the total Federal grant which any one state will receive is to be determined according to the following formula. It shall be the same percentage of \$200 million "as the product of (a) the population of such State, and (b) its percentage of tax-paying ability, bears to the sum of the corresponding products for all the States having plans approved." Tax-paying ability in turn "shall be that percentage which bears the same ratio to 50 per centum as the per capita income of the United States (excluding Alaska) bears to the per capita income of such State," but in no case more than 66% or less than 25 percent. The calculations to be made are simple, but they must be made for all states before it can be determined how much any one state will receive.

The following example will illustrate the general procedure to be followed. Assume a state population of 7 million and total population of 140 million; a state per capita income of \$1600 and a U.S. per capita income of \$2000. The state's percentage of tax-paying ability would be:

$$\frac{x}{.50} = \frac{2000}{1600}, \text{ or } .625$$

which multiplied by its population of 7 million equals 4,375,000. By the same process, this factor is computed for all states having approved plans, and the factors for all other states are added together. Assume that sum to be 65,625,000. Then,

$$\frac{x}{200,000} = \frac{4,375,000}{65,625,000} = \frac{1}{15}$$

Our state would be entitled to one-fifteenth of \$200 million, or \$13½ million.

Conditions that state plans must observe in order to secure Federal approval are laid down in the bill. The major conditions laid down have to do with the nature of the services to be provided.

It is required that the plan be, or within five years become, state-wide, and that it provide: (a) hospital, medical and surgical services for all individuals and families having insufficient income to pay the whole cost, and (b) periodic physical examinations of all chil-

dren in elementary and secondary schools. Nothing whatsoever is said in the bill regarding what shall constitute income insufficient to pay the whole cost. Each state is to establish its own "means test."

The state plan must describe in detail the specific services to be rendered, and those services must be furnished without discrimination on account of race, creed or color, to all persons who are unable to pay the full cost. No qualitative standards are prescribed by the bill, and no control is exercised over the schedule of fees to be paid to practitioners. The medical services may be rendered in the home, office, or in an institution.

The state may pay for services by insuring those eligible to receive them in any voluntary nonprofit health, medical, or hospital insurance fund. It may even establish a compulsory health insurance system of its own. But the state must charge "proper" amounts to those who are able to pay a part but not the whole of the cost incurred. States may, under the provisions of this bill, pay nonprofit private organizations to care for eligible persons. A state may care for them itself, or for some of them, in its own institutions. The state may also under the bill subsidize physicians practicing in areas where a private practice will not yield incomes sufficiently large to attract adequate supplies of medical personnel.

The state plan must describe the financial contributions toward the cost which are to be made by the state, its subdivisions, and private institutions, and the financial support must be adequate to meet the cost of medical services to the medically indigent. It is also required that the state and its local subdivisions contribute at least as much as was contributed for similar purposes in the year 1946, and at least as much as the amount of the Federal grant. The purpose of this provision is to prevent states from reducing their contributions as Federal grants become available. Since expenditures already being made may be counted, most of the "new" money available would come from the Federal grants. Federal obligations for the medical and hospital care of veterans are not modified by any provision of the bill.

Because time will be required to get the entire plan into full operation, priority for services to be provided must be clearly indicated. Furthermore, the entire plan must be based on the results of a statewide inventory of medical, surgical, and hospital care needed, and

special provision is made to assist states financially in taking that inventory. From time to time, the plan and its operations must be reviewed by the state.

Some of the other conditions laid down are as follows: (1) the plan must be administered by a single supervisory agency with authority to carry out its provisions, and within approximately two years that must be the state health agency; (2) there must be provision for a state medical and hospital advisory council, including among its members representatives of state medical and hospital societies, nonprofit medical and hospital plans, and other interested groups.

There are also the provisions common in this type of legislation to the effect that allotments shall cease if the state is not complying substantially with the Federal conditions, if Federal funds have been diverted from their intended purposes, and if the state has failed to provide at least as much money as the Federal government has provided. But any state whose funds are cut off may appeal to a United States Circuit Court of Appeals for relief, and either side may appeal further to the United States Supreme Court. On appeal to the courts, the Director's findings of fact, unless substantially contrary to the weight of evidence, are conclusive.

Dental Services. One purpose of the bill is to encourage states to establish systems of dental care for school children and for persons with low incomes. The method used is to subsidize states having approved plans. Money is provided to assist states in making state-wide inventories of the needs to be met.

A state plan, to be approved, must within five years provide for periodic inspection of the teeth of all children in elementary schools, public and private. It must provide for them dental care and treatment for dental diseases and defects, including prophylaxis, filling, x-ray, extraction, and related care, but not necessarily orthodontia, which is the straightening of teeth. These services must be available only to all children whose parents cannot pay the whole cost of providing them. The state may also extend this dental program to all families and individuals who cannot afford to pay the entire cost. But "proper charges of less than the total cost of the services rendered" must be collected from persons who are financially able to pay a part of the cost.

The services may be provided through insurance in voluntary nonprofit dental care funds, or even in compulsory funds if the state so

wishes, as well as in its own institutions or in nonprofit private institutions. As in the case of physicians, the state may subsidize dentists in areas which cannot normally support them through private practice. The services provided must be available without regard to race, creed, or color.

It might be added that the prepaid nonprofit movement has made practically no headway in the field of dental care. Dentists appear to be convinced that dental health service differs materially from medical health service. The American Dental Association's approach to the problem "is dental education, research, and grants-in-aid to extend the program, and primarily an extensive program for children."⁷ The Association favored the plan proposed in this bill.

The method of determining what proportion of the total amounts appropriated goes to each state is the same as that described above for medical care. Amounts authorized to be appropriated begin at \$8 million and increase to \$20 million each for the fiscal years ending June 30, 1950, and 1951.

The conditions laid down for approval are the same as for the medical care program, with the same right of appeal. They will not be repeated here.

General supervision is by a Director of Dental Care Services, who is in charge of the Office of Dental Care Services, a proposed office in the National Health Agency. Councils are, of course, dental councils.

Provision is made for a National Institute of Dental Research which is to conduct, assist, and foster research and demonstrations relating to the cause, treatment, control, and prevention of dental diseases and impairments. It is also to coördinate similar research done by others and to provide fellowships in the National Institute of Dental Research and in other public and private institutions.

Those opposing compulsory health insurance rallied to the support of the Taft bill. They generally approved it in principle and found relatively little in its detail to criticize, although to some it was merely a lesser evil than a general compulsory system of health insurance. It is not altogether unlikely that some Congressmen favoring a national compulsory health insurance will accept the Taft proposal, not as a substitute, to be sure, but as a step in the general direction they wish to travel.

⁷ Sterling V. Mead, president of the American Dental Association, *Hearings on S. 545 and S. 1320*, 80th Cong., 1st Sess., Part 1, p. 376

The arguments of those opposing the Taft bill may be summarized as follows:

It is not a national health program, and it sets patterns of legislation that go counter to principles developed by progressive medical and public-health leaders during the past 20 years. It establishes the means test as a prerequisite for giving medical care, thus reverting to the outmoded concept of medical care as a charity to the needy. It sets no standards for such limited care as may be supplied under the bill, so that the poor, as today, will probably receive a kind of medical care inferior to that available to those who can afford to buy it. It turns over large Federal and State funds to private agencies with little or no control as to how they will be spent. It creates an artificial and costly barrier between methods of disease prevention and medical care.⁸

The strength of those opposing governmental participation in medical care insurance was sufficient to prevent enactment of the Taft bill.

H. R. 6949: FEDERAL HEALTH SERVICE REINSURANCE

Early in 1954, Mr. Wolverton introduced into the House of Representatives a bill the purpose of which was to stimulate the development of private voluntary nonprofit health service plans. It was believed that if nonprofit associations could reinsure a major portion of the heavy liabilities incurred under some individual policies they would expand their coverage and benefits sufficiently to provide a substantial nation-wide health care program and thus stem the movement for national compulsory health insurance.

It was proposed to establish as an instrumentality of the United States a Health Service Reinsurance Corporation, managed by three full-time directors and capitalized at \$50,000,000, the capital to be provided by Congress. The Corporation was authorized to contract with approved nonprofit health service associations to pay them two-thirds of each claim exceeding \$1000 paid by the associations to any individual subscriber during any twelve continuous months. The reinsurance premium to be paid by each association to the Corporation was set at 2 percent of the total gross payments received from subscribers on all of the association's service contracts.

Approval for reinsurance purposes was made to depend on the inclusion of required provisions in association contracts with subscribers. It was required that association contracts provide only

⁸ Dr. Ernst P. Boas, *National Health Program, Hearing on S. 545 and S. 1320*, Part 2, p. 614.

service benefits and that no cash be payable directly or indirectly under those contracts on account of death, illness, or injury, and that the contracts state clearly all benefits made available, the conditions under which they would be provided, and for what period of time. The premium payable by subscribers to the association would have had to be set in terms of the subscriber's declared adjusted gross income, as computed for income tax purposes, not counting amounts above \$5000, and benefits were to be reduced in proportion to any discovered understatement of income.

For approval of hospital service plans, benefits to subscribers for a minimum and uniform duration of six months in a 12-month period were required, with free choice of any qualified nonprofit hospital, and all qualified nonprofit hospitals in the general area of the service plan had to be eligible to participate. Furthermore, in addition to his premium to the association, the subscriber was to be required to pay the hospital either \$1 for each day of service or 5 percent of the total cost, whichever was the lesser.

Associations providing medical care would have been required to pay 75 percent of the cost of physicians' visits, in the home, office, or elsewhere, except in a hospital, excluding the first consultation, but it could not have paid for more than 12 visits in any 12-month period. The "cost" was to be derived from a fixed scale of charges, arrived at by agreement between physicians and associations. For medical care in hospitals, associations would have paid 95 percent of the cost. All licensed doctors of medicine in the state were to be eligible to participate, subscribers were to have free choice from among participating physicians, and choice of any physician in an emergency.

Applications for approval had to contain an agreement that participating hospitals and doctors would limit additional charges to subscribers for services covered by the plans to a maximum of 25 percent of the amounts agreed upon for those services in association contracts with hospitals and doctors, unless the health service association gave prior written consent to charge more. Associations also had to agree that they would accept any nongroup applicant who applied for membership and paid the premium, that all premiums would be payable in advance, and that out-of-state subscribers would be limited to a maximum of 25 percent of total association membership.

The Corporation's capital of \$50,000,000 was to constitute a re-

serve and to be allocated in equal amounts to a Hospital Service Reinsurance Fund and a Medical Care Reinsurance Fund. Premiums received from associations were to be added to the proper Fund, and Congress was to appropriate amounts equal to the premiums received from associations, which also were to go into the reserve. The reserve was looked upon as a "revolving" fund to be replenished by association premiums and Congressional "matching" appropriations. The Corporation was authorized to borrow from the Treasury, but the aggregate amount outstanding at any given time could not exceed \$25,000,000. All expenses of operating the Corporation, except fees charged against associations for making the examinations required for approval, were to be paid by the United States, except that interest on the reserve could be used for that purpose. Provision was made for terminating reinsurance contracts, voluntarily by associations and by Corporation revocation of approval.

The bill appeared to have substantial support, but late in the session the House voted by a large majority to refer it back to its Committee.

CHAPTER NINETEEN

SOME ARGUMENTS FOR AND AGAINST COMPULSORY HEALTH INSURANCE

THE Wagner-Murray-Dingell bill to establish a national compulsory prepayment medical care system brought forth before the Senate Committee on Education and Labor the best and the worst arguments that could be mustered on the subject. Voluminous testimony pro and con was taken, and that testimony, together with statements submitted for the record, presents a good cross section of American public opinion on the subject.

There was a strong emotional basis underlying much of the testimony on both sides, with little if any attempt being made to conceal inherent bias. Yet an abundance of expert testimony was presented and ably discussed. There was also extensive and active participation in the hearings by some of the members of the Committee, mostly of an *ex parte* character. There was even some hostility manifested between certain members of the Committee. As would be expected, nearly every argument put forth, whether for or against, was challenged. It seems worth while to reproduce here some of that argument, although no attempt will be made to summarize the hearings.

ARGUMENTS FOR COMPULSORY INSURANCE

Representatives of a small minority of the medical profession appeared in favor of a national compulsory system. The Physicians Forum, the Committee for the Improvement of Medical Care, the National Medical Association, and the Dentists Committee for the Passage of the Wagner-Murray-Dingell Bill, were all represented in behalf of the bill. Officials of several Federal Agencies threw their

weight into the balance, including the Social Security Board, Federal Security Administration, Public Health Service, Department of Agriculture, and Department of Labor. Organized labor, including the American Federation of Labor, the Congress of Industrial Organizations, the National Women's Trade-Union League, and the Brotherhood of Railroad Trainmen, vigorously supported a national system financed by taxes on employers and employees. Social and welfare groups testified to the need for compulsory legislation, and were represented by the American Association of Social Workers, the American Association of Medical Social Workers, the National Commission on Children and Youth, the Methodist Federation for Social Service, the Southern Conference for Human Welfare, the National Federation of Settlements, the National Conference of Catholic Charities, the National Catholic Welfare Conference, and the National Association for the Advancement of Colored People. The American Association of University Women, the Council for Social Action of the Congregational-Christian Churches, the National Lawyers Guild, the Independent Citizens Committee, the National Consumers League, the American Veterans Committee, and the National Farmers Union also appeared in behalf of the bill. Others not listed here also appeared. The burden of their argument was that a national compulsory system is needed and that such a system is not contrary to American ideals and institutions.

The Need. Those who favored compulsory health insurance presented data showing that medical care is now inadequate, unevenly distributed, and expensive, and that as a result large numbers of people do not get the medical care they need. Much of the information given in Chapter 17 was used to support the argument that there is a crying need for a method of paying for medical care which will provide adequate facilities and distribute them properly. And they believed that compulsory health insurance is that method. One eloquent plea based on need was made by Senator Robert F. Wagner, staunch supporter of all forms of social insurance and one of the sponsors of the bill. He said:

Every year thousands of mothers and children are dying needlessly from preventable causes. Every year thousands of men and women in the prime of life are dying needlessly from tuberculosis, pneumonia, influenza, and other preventable diseases. . . . Every year we lose more

persons from preventable and premature deaths than we lost on the battlefields during all of World War II.

We cannot allow these preventable deaths to occur year after year. Every year of delay in establishing a national health program means the loss of thousands of lives. Every year of delay means needless suffering to thousands of people who do not now obtain adequate medical care. In the past we have taken some small piecemeal steps to try to deal with the problem. Now what we must do is tackle the job with everything we have.

The most important way now to accomplish that purpose is by the enactment of a national health insurance plan supplemented by other improvements in existing health legislation.¹

Natural Extension of Social Security. One point, stressed by many, was that after all health insurance is really nothing so revolutionary, but is rather just a logical and necessary expansion of what we already have. Considerable progress has been made in developing a system of social security for the United States. Old age insurance is provided by the Federal Old-Age and Survivors Insurance system, the Railroad Retirement system, the Civil Service Retirement system, and other Federal retirement plans, as well as by retirement systems for state and local government employees. Many are still not included, but marked progress has been made. Some progress has even been made in the direction of retirement for disability. Old-age assistance programs have been developed which meet the most pressing needs of the indigent aged. Every state has an unemployment compensation system and coverage is growing. Workmen's compensation has long been in operation and is playing an important role in the reduction of insecurity. And assistance is provided for such needy groups as the blind and the crippled, needy mothers and dependent children.

"The lack of adequate measures to cope with sickness and sickness costs constitutes the most serious gap in provisions for social security in the United States."² A system of health insurance would fill the last remaining large gap in our social security legislation.

Merchant seamen have since 1798 received medical care administered by the United States Public Health Service and supported by

¹ United States Senate, *National Health Program, Hearings Before the Senate Committee on Education and Labor on S. 1606, a Bill to Provide for a National Health Program*, 79th Cong., 2nd Sess., Government Printing Office, Washington, 1946, Part 1, pp. 52-53

² Arthur J. Altmeyer, *loc. cit.*, Part 1, p. 172.

social insurance and tax funds. Medical and hospital care are now being supplied free to millions of veterans. This last point has been summed up in another connection as follows:

Few people seem to realize that the American people are already committed to one of the largest experiments in government medicine yet seen in the world. We are to provide complete, free hospital and medical care in the hospitals for from twelve to fourteen million service men and women in veterans' hospitals staffed by salaried physicians. The cost is met from taxation. Veterans receive complete hospital care with the service of physicians. Although originally intended for service-connected disabilities, the language of the statute makes the test for ability to pay for nonservice-connected illnesses only a formality. No attempt is made to collect from the veteran unless he has insurance coverage, in which case an effort is usually made to collect from the carrier. In practice, the government pays. Proposals have recently been introduced to remove all reference to the financial status of a veteran seeking care.³

Cash disability benefits are already available under the Railroad Unemployment Insurance act and under several state acts as well. Private voluntary prepayment and commercial hospital and medical care plans help, but they do not reach the ones most in need of protection, namely the lowest-income groups. A system of health insurance would fill that gap and would bring the United States abreast of leading foreign countries in the field of social insurance. It would weld together the many small programs now in operation, spread the movement to those not yet covered, or to most of them, and lift the whole to a higher level.

Some argued that voluntary insurance had developed sufficiently to fill the gap. But that was denied, and the experience of other countries was offered as evidence. A study made by A. M. and Nathan Simons for the American Dental Association in 1931 was discussed. That study found, among other things, that "every attempt to apply the principles of voluntary insurance on a large scale has proved to be only a longer or shorter bridge to a compulsory system. Every so-called 'voluntary' system is successful in just about the proportion that it contains compulsory features."⁴

Economically and Financially Sound. It was estimated that a comprehensive system of medical care would cost about \$3.5 billion

³ Louis H. Pink, *The Story of Blue Cross*, Public Affairs Pamphlet No. 101, Public Affairs Committee, Inc., pp. 29-30, 1945.

⁴ *Hearings on S. 1606*, Part 2, p. 646.

the first year and somewhat more in later years as added benefits were introduced. In terms of pay roll, it was estimated to run from 3 to 4 percent. The total cost would of course depend on the scope of benefits provided, and there was considerable difference of opinion as to the ultimate cost. Civilian health and medical expenditures for families amounted to about 4 percent of income; and public expenditures for civilian health then ran about \$1 billion annually.

Proponents argued that a compulsory system would not add a new burden, but would merely provide a new method of payment. "The bill does not impose additional cost; it is merely a device to permit us as consumers of medicine to pool our small contributions and thus build a reserve large enough to meet, above all else, the crippling blow of major illness. This is primarily a problem of consumer organization."⁵ William Green, president of the American Federation of Labor, testified that though it might be costly, still he could not conceive of anything that would be a better "asset of the Nation than good health."⁶

Spreading the burden of medical care among many by the insurance method is a sound economic and financial procedure. It is true that some will pay more than they now do and will receive no more. But that is characteristic of the method of social insurance. However, it should be noted that those who say that the total cost will not be increased, but that what is now being spent will merely be spread out, seem to forget that much will be spent for medical care outside the system by people who pay taxes under the system. Furthermore, if a really good system is established, it will cost more than we are now spending, because we simply are not now getting as good medical care as we want and can provide. As one doctor put it: "If American medicine is to be good, it will be expensive. . . . Cheap medicine will mean poor medicine, and that, in the long run, will be expensive."⁷

Federal contributions may be necessary to keep the direct cost to employers and employees down, and they can be justified on that ground. Government is now contributing to the medical care of many, and this much would not represent a new cost. But if still higher contributions by Government are needed, they will merely

⁵ Dr. Alice Hamilton, *loc. cit.*, Part 2, p. 978. See also Arthur J. Altmeyer, Part 1, p. 206, and James B. Carey, secretary-treasurer, C.I.O., Part 3, p. 1519.

⁶ *Loc. cit.*, Part 1, p. 476.

⁷ Dr. Allan M. Butler, *loc. cit.*, Part 1, p. 416.

represent a particular choice in the method of collecting funds. The money would simply be got by increasing income or other taxes instead of the pay-roll taxes. Much of it would come from the same sources as the pay-roll taxes.

It was also argued that a compulsory system, by reducing the volume of sickness and disability, increases the ability of workers and employers to pay premiums and to secure more adequate medical care. A slight reduction in the amount of illness would result in a substantial saving in working time lost. This, to be sure, is a hope, but to proponents of the system a reasonable hope.

Improved Medical Care. Those who favor a compulsory medical care system are generally convinced that such a system will improve the quality of medical care and reduce the volume of sickness, and they gave specific reasons for their belief.

In our opinion, the passage of this bill would definitely encourage high-quality medical care. Doctors with whom we have consulted have informed us that when the ability of the individual patient to pay is a factor in his prescription of treatment, as it is under the present system, the best quality of service is often denied. Under the contemplated program this barrier would be removed. Patients would also be encouraged to visit the doctor in the early stages of illness.⁸

All too often the physician is prevented from giving his patient the benefit of the full resources of medicine because the patient cannot afford the expense of the procedures involved. The doctor is unable to practice medicine in the way he wishes and in the way it should be practiced. . . . Most physicians enter and remain in the field of the practice of medicine because they derive a sense of satisfaction from the prevention and alleviation of sickness. Under this bill the physician will find his relationship with his patients unimpeded by economic barriers. No longer will the problem be whether the patient can afford the treatment the physician thinks is necessary. No longer need the physician hesitate to call for the complete working up of any case, regardless of cost. No longer need the patient wait until the disease becomes acute before consulting the physician. For the first time, preventative and curative medicine can come into its own on the largest possible scale.⁹

Some argued that a compulsory system will increase facilities and result in a better distribution of facilities and personnel. There is

⁸ The Reverend Jack R. McMichael, executive secretary, Methodist Federation for Social Service, *loc. cit.*, Part 1, p. 469.

⁹ Dr. Ernst P. Boas, Physicians Forum, *loc. cit.*, Part 2, p. 738.

general agreement, even among those who oppose a compulsory system, that there is a maldistribution of personnel and facilities "What is more, there are no signs of improvement, and the pattern of settlement elected by thousands of physicians and dentists leaving the armed services is serving further to exaggerate present disproportions. . . . There seems to be no prospect of solution of this crisis . . . unless steps are taken toward equalizing the financial support for medical services in all parts of the Nation."¹⁰

The South is especially hard hit, with its rural areas and its large Negro population.

We in the South know a lot about ill health and inadequate medical care, because we have more of both than any other section of the country. . . . Our rural and our Negro populations are hit the hardest, but our industrial workers and the middle-income groups are not so much better off. . . . The two main sources of this misery are clear, namely, poverty and inadequate medical services. . . . The private medical insurance we can get now is far too expensive and does not meet our health needs. . . . Blue Cross hospitalization is good as far as it goes, but it does not go very far. . . . A national health program . . . is necessary if we are to get more hospitals, public-health services, doctors, dentists, and nurses, and to be able to go to them when we need medical care.¹¹

One doctor said. I think there is no question . . . but that legislation of this kind, would make possible to almost every section a kind of medical care that very few of our population have had.¹²

Not only would there be more facilities and a better distribution of personnel and facilities, but, it was argued, there would be better coordination in the entire system.

As science advances, it becomes more and more important to coordinate the services of family practitioners, specialists, laboratories, and hospitals. High quality medical care cannot be obtained without such coordinated services. However, employment of specialists, consultants, laboratory, and other services costs money—more money than most people can afford to pay. And that is one reason—and a very important one—why most people do not obtain high quality medical care at the present time.¹³

¹⁰ Dr. J. W. Mountin, medical director, U. S. Public Health Service, *loc. cit.*, Part 1, p. 140.

¹¹ Dr. Clark Foreman, President of the Southern Conference for Human Welfare, *loc. cit.*, Part 1, pp. 353–368. See also Dr. W. Montague Cobb, *ibid.*, pp. 501 ff. and Dr. E. I. Robinson, Part 2, pp. 787 ff.

¹² Dr. Frederick D. Mott, chief medical officer, Farm Security Administration, *loc. cit.*, Part 3, p. 1181.

¹³ Dr. Harold Aaron, *loc. cit.*, Part 3, pp. 1254–1255.

A compulsory system will, it is believed, also improve medical practice by furthering research.

[It] will increase the quality of medical care by freeing doctors to use laboratory and other techniques now often neglected because of cost. The quality of medical care receives an additional boon by the provisions encouraging medical research, basic medical training, and special graduate work.¹⁴

What virtues American medicine may have lie in the potential powers which have been given to it by scientific discoveries for which we have come to depend almost entirely upon salaried persons in institutions. The present system of practice, by isolating physicians in offices, effectually removes them from the field of scientific endeavor. By reason of this remoteness they are deprived of the contacts needed to give them even an understanding of the scientific tools they may use. Competitive practice on a fee-for-service basis furnishes no medium for the training of experts or medical methods. Its complete failure in these respects was never more evident than it is at this moment when we are confronted with the problem of reeducation and relocation of returning medical officers.¹⁵

One witness, discussing the effect of insurance on the integrity of the medical profession, observed: "Surely they attack the integrity of our practitioners when they suggest that the quality of care would decline merely because the doctor is assured of payment."¹⁶

Proponents generally believe that with health insurance the method of practice will improve. One argued:

The time-honored general practitioner who rendered all aspects of medical care to patients, is a casualty of the progress of science. We must face the fact that the total knowledge available for the care of patients today cannot be mastered by an individual physician. Modern medical care of the sick patient requires the services of not one but many physicians, as well as highly trained technical and nursing personnel skilled in the use of complicated apparatus and delicate techniques. . . . Whatever limitations group practice might impose on the action of an individual physician would be balanced by the group's consideration of each member's qualifications, limitations, and personal needs.¹⁷

¹⁴ The Rev Jack R. McMichael, executive secretary, Methodist Federation for Social Service, *loc. cit.*, Part 1, pp. 458-459.

¹⁵ Dr. John P. Peters, *loc. cit.*, Part 2, p. 985.

¹⁶ Dr. Alice Hamilton, *loc. cit.*, Part 2, pp. 977-978.

¹⁷ Dr Allan M. Butler, *loc. cit.*, Part 1, pp. 411, 412. But see Dr. Franz Goldman, Part 4, p. 2229: "The need for the general physician is illustrated in

Not all those who favor a national compulsory system believed that improved medical care will follow necessarily and immediately. One expressed himself as follows:

In spite of the arduous work involved in the drafting of this legislation and the long and earnest inquiry and effort given to perfecting its provisions, its passage cannot be expected to usher in an immediate millennium of health. It prescribes no changes in the present order of medical practice. It merely enables physicians to give and patients to receive more medical care by giving or distributing the funds to meet its cost. Its proponents and supporters, however, sincerely hope that it will lead also to improvement in the quality of medical care, which, in turn, must involve changes in the method of practice. What direction these changes should take can be determined only by experiment, which must, therefore, be fostered by the program.¹⁸

A national system, with its supervised minimum standards, it was argued, would at least result in more uniform quality of medical care than now exists. It would also result in a more uniform quantitative distribution of medical care.

Benefits to the Medical Profession. It was argued that a compulsory system will be decidedly beneficial to the medical profession, and in many different ways.

First of all, it will enable the profession to give the patient the best possible professional care, and thus actually enable it to enjoy the satisfaction of preventing and alleviating sickness, a purpose for which most physicians are said to enter and remain in the profession. Specialists, equipment, laboratories, and time will all be available, and cost will not be a deterrent to their fullest use. As one of the doctors said, it will bring "release from the economic restrictions which have kept physicians from the full development and exercise of their powers. I can see in it the promise of a bridge across that

this true story of six specialists and no doctor. There was a man with inframammary pain who betook himself to a cardiologist, who suspected a spinal-cord lesion and sent him to a neurologist who diagnosed spinal osteoarthritis and sent him to a radiologist whose x-rays revealed nothing. . . . Being still in pain he went a little later to a chest specialist who discovered nothing but suspected a psychoneurosis and sent him to a psychiatrist who refused to get to work until the man had been to a clinical pathologist who reported that all blood examinations were normal. The patient returned to the psychiatrist and was still in conference when last heard of."

¹⁸ Dr. John P. Peters, *loc. cit.*, Part 2, p. 984.

great gap between the potentialities and accomplishments of medicine.”¹⁹

There will be freedom of choice, for both doctor and patient.

. . . There will be no interference between normal relationship between doctor and patient. Every person insured under the act will have the absolute right, within the framework, of choice, subject to the right of the physician to refuse to accept the patient, and the patient to choose the doctor who may treat him.²⁰

Some restrictions will have to be placed on the number of patients a doctor can treat under the plan. But those restrictions will not be serious or severe and will serve to protect both doctor and patient rather than restrict them. It was pointed out that under the present system there is not a great deal of freedom of choice. People with low incomes are definitely and severely restricted in that respect. “There is far less freedom of choice today than many people realize. Our rural and small town people have little choice.”²¹

The relationship between doctor and patient should, if anything, be improved. Freedom of choice on both sides will help. Furthermore, no fee enters into the relationship, which, it is said, should make for a freer and easier intercourse. The family physician can still be the family physician. But on this score, a bit of interesting testimony was introduced. Miss Helen Hall, Director of the Henry Street Settlement, said that a first-hand study made in 1938 by the National Federation of Settlements in 23 cities located in 16 states showed that two-thirds of those interviewed had no family physician.²²

Against this should be set the findings of the National Opinion Research Center, University of Denver, and of the Opinion Research Corporation, that 77 percent of families of three or less and about 82 percent of families of four or more, have regular family physicians. In “settlement” areas, one would expect few persons to have family physicians.

A doctor’s opportunity to practice in a community where he would like to live and to raise his family would be greatly increased by a

¹⁹ *Ibid.*, Part 2, p. 986.

²⁰ Mr. Leo J. Linder, National Lawyers Guild, *loc. cit.*, Part 1, p. 259.

²¹ Dr. Alice Hamilton, *loc. cit.*, Part 2, p. 974. See also Dr. Frederick D. Mott, chief medical officer, Farm Security Administration, Part 3, pp. 1179-1181.

²² *Loc. cit.*, Part 1, p. 321.

health insurance system. Many of the smaller cities and rural areas would have the necessary medical facilities, and the income problem would be solved. Thus existing obstacles would be removed.

Doctors will be better able to increase their skill and knowledge under a national system of medical care insurance. Not only will they have more time for each case and be able to use consultants, but provision will be made for them to take refresher courses from time to time. Furthermore, special provision will be made for basic research that will advance the science and art of medicine.

Finally, and not least in importance, the profession's financial condition will be improved. Income will be more adequate. "With the increase in the cost of medical care, the charity tradition is placing an impossible burden on physicians."²³ A compulsory national insurance system will do away with that burden. Income will be more stable and will be received more regularly and promptly.

Voluntary Insurance Inadequate. It is argued that a voluntary system cannot possibly provide a satisfactory solution to the problem, and for many reasons.

For in the first place, it will be impossible ever to get anywhere near complete coverage in a voluntary system. No voluntary movement in any country has ever yet approached complete coverage. Many people are unable to pay the necessary premiums, and many who are able to pay simply will not do it. Membership in existing voluntary prepayment medical care plans in the United States includes only about 5 percent of the civilian population despite the intense promotion that has been put into the movement, and there is no good reason to believe that it will ever approach 50 percent. Membership restrictions are imposed in order to avoid adverse risks, and sometimes to exclude high-income groups. Sometimes membership restrictions are imposed in the interest of effective and economical administration.

Furthermore, benefits are usually severely limited in voluntary plans. Certain services, such as dental and eye care, are generally not given, while others are supplied only in limited quantities. This is done partly to keep premiums down, partly to facilitate administration, and partly because specialists hesitate to include their lucrative skills in a common pool. Services in voluntary plans tend to be related directly to the average per capita wealth of the areas in

²³ Dr Allan M. Butler, *loc. cit*, Part 1, p 413

which they are established. Rural plans generally provide extremely limited benefits, largely because of the relatively low incomes of farmers, but partly because more adequate facilities are not available.

Voluntary plans are entirely too costly, and necessarily so by their very nature. They must be promoted, which is an expensive operation, and the promotion must be continuous. For many who are induced to join in the beginning drop out and must again be lured into the plan, or into another. The turnover in membership is great. Administrative costs are high, and here again necessarily so. Many small units require considerable personnel, and there is much overlapping and duplication.

Nor are contributions related to ability to pay, as they must be if income sufficient to provide reasonably adequate benefits is to be secured, and as they would be in a compulsory national system. This argument is frequently found in the same list with the argument that many voluntary plans are unfair because they permit doctors to charge extra fees from those who can afford to pay. There is an obvious inconsistency between the two.

Voluntary plans, it is argued, are not democratic. They do not reach the lowest-income groups, which are the ones who need protection most. Furthermore, they do not usually give consumers any voice in the management of the plans. Plans sponsored by the American Medical Association and Blue Cross hospitalization plans sponsored by hospitals are examples. These are in general producer-controlled. The consumers have nothing to say about how the plans are to be organized or operated.

And finally, voluntary plans are not suited to our increasingly migratory population. It is true that something is being done to provide for transfer of membership from one plan to another. But in a system of voluntary insurance, the problems are much more cumbersome than they would be in a compulsory system, and effective arrangements will at best be complicated and expensive.

The greatest value of voluntary plans, it has been said, is the experience that they have given us. That experience shows conclusively that a national compulsory system is the only way in which comprehensive and adequate medical care insurance can be provided.

Voluntary plans would not be abolished, but would be integrated into a comprehensive national system. Indeed, they would be encouraged.

All qualified hospitals, all qualified medical groups or organizations, will be able to participate in the program as organizations furnishing services to the insured persons who choose them; they will receive fair payments for the services they furnish under the bill; and they will have enlarged opportunities to be service agencies for particular groups or for their communities. This applies to service organizations created by trade unions, consumer groups, employers, non-profit community groups, churches, fraternal associations, groups of doctors, medical societies, or many other kinds of sponsors, or groups of sponsors. The bill not only provides for utilizing existing service organizations but it also encourages the creation of new ones.

Medical service groups . . . furnishing service under the system would be as free as they are today to select their own staffs and their own methods of paying physicians and others on their staffs, irrespective of the method of payment which prevailed among the individually practicing physicians or dentists of the local area.²⁴

Compulsory Plan is in American Tradition. Many are convinced that a compulsory medical care plan is strictly in harmony with American traditions, as the following quotations will show:

We are nearing the realization of an old American dream—the dream of equality of opportunity for everyone to obtain good medical care.²⁵

It is somewhat analogous to the change that was made in the support of education upward of a century ago.²⁶

There is nothing foreign to our system of government in the provision of medical care for the people of our country by an insurance system. It is no more foreign to our system of government than is the system of old-age security and unemployment insurance. In fact, one of the very first health insurance systems introduced in the modern world was established in the United States in 1798 when Congress enacted the health insurance system for merchant seamen. With some variation, this has existed for nearly 150 years.²⁷

I think that we are a social nation, and as far as this proposal being a socialistic one, it cannot be more than democracy in its highest essence because this program cannot be inaugurated without the consent and support of the American people. If democracy means socialism, I accept the soft impeachment.²⁸

If these charges (of radicalism) are true, why is it that such eminent businessmen as Gerard Swope of the General Electric Co., David Sarnoff

²⁴ Senator Robert F. Wagner, *loc. cit.*, Part 1, p. 55.

²⁵ Dr. Franz Goldman, *loc. cit.*, Part 2, p. 614.

²⁶ Dr. J. W. Mountin, *loc. cit.*, Part 1, p. 155.

²⁷ Leo J. Linder, National Lawyers Guild, *loc. cit.*, Part 1, p. 274.

²⁸ Watson B. Miller, federal security administrator, *loc. cit.*, Part 1, p. 131.

of RCA, and a number of other businessmen, bankers, publishers, and individual doctors and dentists have endorsed compulsory health insurance as "a thoroughly American plan, consistent with our tradition of using Government to aid the people in doing things for themselves?"²⁹

Some went even further than to say that compulsory national health insurance is strictly in the American tradition and argued that the establishment of some such system will safeguard our capitalistic democracy.

In answer to the question whether socialism or communism would be stimulated by the passage of the bill, one witness said: "Oh, I think just the opposite. The cause of communism in a country, or socialism either, I think is widespread poverty among people, and if we can prevent some of that poverty we to that extent fight communism."³⁰

William Green, president of the American Federation of Labor, said that "enactment of legislation of this kind will do more to maintain and establish our free enterprise system in America than anything I can think of."³¹

National System Preferable. There are many advantages in having a national system rather than separate systems in the different states. This would be true even if the Federal government were to specify minimum basic standards for approval of state acts.

A national system would certainly distribute personnel and facilities more uniformly throughout the country, among and within states, and the medical profession agrees that a more uniform distribution is needed. There probably would be more facilities and they would probably be utilized more fully. It would greatly facilitate the handling of our increasingly mobile industrial population, both in regard to collection of taxes and the provision of medical services. Administration should be more economical, with less duplication of efforts, fewer records and reports, and on the whole more efficient personnel.

Basic minimum standards of adequacy can be secured in a system of state acts, but only if there is a national act which specifies those minimum standards. Experience with state unemployment compen-

²⁹ John D. Dingell, Representative in Congress from Michigan, *loc. cit.*, Part 1, p. 84.

³⁰ The Rev. R. A. McGowan, director, Department of Social Action, National Catholic Welfare Conference, *loc. cit.*, Part 3, p. 1672.

³¹ *Loc. cit.*, Part 1, pp. 484-485.

sation acts seems to indicate that a national system will be better suited to achieve a basic minimum level for the country as a whole. A national system could also eliminate the competitive disadvantage that a state with higher standards might suffer. It might be noted, in connection with this argument, that any such disadvantage would appear to be of little real importance. There is, for example, little evidence that more liberal workmen's compensation and unemployment compensation laws have damaged states having them or that the less liberal laws have been advantageous where they exist.

Senator Claude Pepper summed up these and other advantages as follows:

To cover everyone, the adverse, as well as the good, risks, the young and the old, the sick and the well, the rural and the city dwellers, the low and the high-income groups, the poor and the rich areas, all this takes a mechanism as representative and all-inclusive as the Federal Government. Some people will not protect themselves voluntarily even if they are able to do so; others will be able to afford to do so only under a national plan. A national solution by spreading the risk among the whole population, and by equalizing costs between income groups and areas, will enable all the people to protect themselves at a cost they can afford.³²

Others spoke in the same general vein:

On a nation-wide basis, the cost of medical care would be related to ability to pay, and services would be provided in accordance with health needs. Administrative costs would be lower; payments for professional services would be more ample. There would be equitable spreading of funds between areas of varying wealth. Rural sections, with their generally lower-income levels and their greater medical care needs, would be particularly benefited. The scope of health services would be considerably broader and the quality more uniformly high.

Passage of a national health bill would not, of course, create adequate medical care for all persons overnight. It would, however, make immediately accessible to all insured persons the medical personnel and facilities at hand in their communities. More important, the medical services furnished an individual would be determined by his need of them and not by his bank balance.

Moreover such a program would go a long way to encourage a better distribution of physicians and dentists around the Nation. Existing institutions as well as institutions to be built under the proposed national hospital construction program would be assured of proper financial maintenance.

³² *Report of the Senate Sub-Committee on Wartime Health and Education, Health Insurance*, quoted in *loc. cit.*, Part 1, pp. 112-113.

Medical and allied personnel would no longer have to concentrate in larger cities to make a living, and the people of our great rural districts would become supplied with their fair share of doctors and other health workers.³³

ARGUMENTS AGAINST COMPULSORY INSURANCE

There was no lack of argument against compulsory health insurance. Most of the opposition came from the organized medical profession, especially from the American Medical Association, its component parts, and what was called its "satellite," the National Physician's Committee, from the Association of American Physicians and Surgeons, the American Academy of Pediatrics, the American Dental Association, and others. The American Hospital Association, the American Protestant Hospital Federation, and the Catholic Hospital Association added their weight against the bill. The American Bar Association appeared in opposition. The National Association of Manufacturers, the Committee for Constitutional Government, the America First Party, and the Insurance Economics Society of America were all represented in opposition. The Fraternal Order of Eagles, well known for its efforts to promote old-age assistance laws in earlier days, registered its protest against compulsion. Three farm organizations were opposed to compulsory insurance—the Grange, the American Farm Bureau Federation, and the Farm Foundation. Not all of these appeared before the Senate Committee. Many other organizations and individuals went on record against any form of compulsion. The main burden of their argument was that a compulsory system is not necessary and that it is not in harmony with American ideals and institutions.

The Need. No one argued that adequate medical care is now available to all who need it, but the extent of the need was played down by eulogizing the progress that has been made.

The nation's health is not grave, since the United States now has the lowest sickness and death rates of any large nation in the world. . . . A pilot study made under the auspices of the Selective Service System during the war at the request of President Franklin Delano Roosevelt failed to show that the application at Government expense of everything that scientific medicine had to offer yielded a sufficient number of corrected defects to make the project worth while. . . . The actual figures show

³³ Dr. J. W. Mountin, *loc. cit.*, Part I, pp. 143-144.

that the amount of time lost from work by absenteeism due to illness is greater in every foreign country in which a compulsory sickness insurance system prevails than it is in the United States. . . . Our principal problems in medical care are the control of certain diseases in certain segments of the population. Improvement applied specifically to the problems in these diseases and addressed to these segments of our population would bring about a vast general improvement in sickness and death rates for the Nation as a whole.³⁴

Literally billions of dollars have been donated by churches, philanthropic organizations, public-spirited citizens, and various community groups to build hospitals to provide care for the people of this Nation. Benjamin Franklin was one of the trustees of the first voluntary, nonprofit hospital in the United States, and the hospital he helped to found is still in operation as a monument to the civic interest of this great American genius.³⁵ Since that time, outstanding citizens in every section of the country have been members of boards of trustees of hospitals in their local communities, in recognition of the importance of the hospital to the people of the area. These tens of thousands of trustees are the representatives of the general public organized to supervise the policies of the hospital with respect to the needs of the individual community, and to see that the institution renders its fullest measure of service to its citizens. Representatives of our various church groups have fulfilled a similar purpose in operating hospitals in areas where they are needed.

Within the walls of hospitals in every part of the Nation, thousands of physicians, nurses, hospital administrators, and other personnel have individually and collectively contributed to the development of a system of hospital and medical care which draws very little criticism except that there is not enough of it. The strength of this system is that it has grown and is continuing to grow according to the needs of the people it has served. It is rooted in many soils, and has developed along various lines. Today's health care system is a living, growing organism which is instantly adaptable to the latest scientific discoveries, or to the needs of the community, or to the individual patient.

We are keenly aware of the fact that the amazing development of hospital services over the past two generations has been the result of those incentives which are found only in a free and independent professional group devoting their whole attention and interest to their efforts to be of service to society.

³⁴ Dr. R. L. Sensenich, chairman of the Board of Trustees, American Medical Association, *loc. cit.*, Part 2, pp. 557-559

³⁵ The witness did not quote the following passage from Franklin's autobiography: "I do not remember any of my political manoeuvres, the success of which gave me at the time more pleasure, or wherein, after thinking of it, I more easily excus'd myself for having made some use of cunning."

If the control of the funds of a compulsory health insurance system be placed in the hands of the Federal Government, the continuing growth of our present system which has brought such progress will be seriously affected, because, administratively the Federal Government will have to adhere to a single pattern of providing care.³⁶

It was argued that "we now have the best national health in any country in the world. Why interfere with this situation?"³⁷ It was also argued that "the major portion by far of the American population, and I mean the population of the United States, have had sufficient funds to get good medical care. . . ." ³⁸ The number of people "who have not had medical care because they neglected the case, or because they feared the expense" was found by one doctor to have been negligible in his experience.³⁹ Another found that the "economic need for spreading the cost of medical care is rapidly being taken care of" through voluntary plans.⁴⁰ It was generally admitted that some are too poor to pay, but it was insisted that most of the poor get good treatment as charity patients or at very low fees.

Not a Natural Extension of Social Insurance. Admitting that some types of protection are useful and desirable, one witness argued that a compulsory system of medical care insurance at that time would be contrary to the moral law.

It is man's duty to take care of his health and of the health of those who are dependent upon him and that duty is binding upon him by virtue of the natural law which obligates every reasonable and rational human being and which exercises compulsion over man within the full limits of his financial and physical capacity, to obey it. . . . The compulsion in this obligation . . . still leaves the individual free in the full enjoyment of a vast freedom because the obligation is not specific with reference to this or that method of living up to my obligation. . . . Man is not obliged to choose one method rather than another of safeguarding his health. . . . We recognize the compulsion of the obligation but we deplore the compulsion as to the method of complying with that obligation.

We cannot create an intelligent and enlightened and a responsible citizenry unless we entrust duties and obligations to that citizenry. . . . If

³⁶ John H. Hayes, president-elect of the American Hospital Association, *loc. cit.*, Part 3, pp 1690-1691.

³⁷ Dr. John W. Green, *loc. cit.*, Part 1, p. 541.

³⁸ Dr R. L. Sensenich, *loc. cit.*, Part 2, p. 568.

³⁹ *Ibid*, p. 585.

⁴⁰ Dr. George L. Carrington, chairman, Medical Society of North Carolina Committee, *loc. cit.*, Part 2, p. 620.

society could not create and could not maintain the processes by which the human being can meet this obligation of his health care, then the Government would have to give aid to society and ultimately to the individual so that society might meet this obligation. . . . Is it apparent that the system of private initiative in medicine has so completely failed as to justify this extreme compulsion? . . . Can society really create or maintain the processes necessary for safeguarding the health of the Nation? If our question pertains to American society, my answer is unhesitatingly and unqualifiedly an emphatic "Yes" If we can achieve our purpose through the encouragement of voluntary initiative, we shall safeguard the dignity of the individual as that of a person who is intellectually and emotionally competent to make his own choice concerning the manner in which he obeys the natural law to which he is subject.⁴¹

Economically Unsound. Opponents did not miss the opportunity offered by the uncertainty as to how much a comprehensive compulsory system would cost. They argued that the cost would be excessive.

Administration of this compulsory insurance and socialized medicine plan would be exorbitantly expensive and a back-breaking tax burden for already overburdened American taxpayers.⁴²

When compulsory health insurance was proposed in California . . . no one appeared with any sound idea as to its cost. The guesses varied between \$20 per person per year and \$80 per person per year. Most thought that \$40 was a fair figure. . . . At \$40 per person per year, the program would cost \$4,000,000,000, and no one really knows whether this amount would suffice. Experience elsewhere indicates that there is needed at least one employee (not including those actually delivering medical service) for each 100 insured persons. . . . On this basis we would need to increase the Government payroll by about 1,500,000 employees. . . . This is a rich country, but no wealth is unlimited.⁴³

If an adequate staff and organization were provided, it would mean an army of Government employees. Under our "spoils system," such an expansion in the number of Federal employees could mean patronage—patronage for whatever political party was in power, patronage beyond anything dreamed of in the past, patronage down into every local community in the United States.⁴⁴

⁴¹ The Rev. Alphonse H. Schwitalia, president of the Catholic Hospital Association, *loc. cit.*, Part 3, pp. 1793–1796.

⁴² Dr. Harold T. Low, president, American Association of Physicians and Surgeons, *loc. cit.*, Part 2, p. 798.

⁴³ Dr. Lowell S. Goin, *loc. cit.*, Part 2, pp. 626–627.

⁴⁴ Fred Bailey, legislative counsel, The National Grange, Inc., *loc. cit.*, Part 3, p. 1642.

We are further opposed to this legislation because it has been our experience that Government in the field of health is seldom able to control its costs of service, and on the other hand is likely to promise greater benefits than funds will permit. Between a steadily rising cost of benefits, and an increasing demand for more of such benefits, the Government would soon begin to operate under tremendous financial pressure. . . . Certainly this may become one of the most expensive programs the Federal Government has ever undertaken. . . .⁴⁵

Furthermore, it was argued that such a system would impose an unfair tax burden on the higher-income groups, who would be called upon to defray a part of the medical cost of the lower-income groups. Many of the people in higher-income groups would in addition use doctors not working under the system and would consequently pay "double." The lowest-income groups could not be included, because they do not have income enough to pay the necessary premiums.

Voluntary Plans Preferable. Recently there has been a rapid growth in voluntary prepayment medical care plans. The American Medical Association, reversing its traditional position, has been aggressively promoting the movement, although it is probable that at the moment the medical profession is merely choosing it as the lesser of two evils. Nearly all organizations and individuals opposed to compulsory health insurance believe that voluntary plans will in time do the job and do it better, as the following quotations show.

(We) are the best insured Nation in the world from the point of view of life insurance, and strictly on a voluntary basis. There is no reason to believe that American initiative applied to the development of voluntary prepayment medical care plans could not bring about an equally favorable result with medical care insurance.⁴⁶

If it be argued that no voluntary plan completely meets the need, I reply that that is true, but that evolution is not a rapid process and that in a field in which there is little or no experience, haste must be made slowly. These plans, which already include a very large number of persons, are in accord with our traditional emphasis on personal responsibility, prudence, foresight, and thrift. They have an American dignity which is lacking in the regimentation of compulsory health insurance. They can be and are more economically administered, they can and do give better medical care, and they will be and are supported by thousands of physicians who

⁴⁵ John H. Hayes, *loc. cit.*, Part 3, pp. 1691-1692.

⁴⁶ Dr. R. L. Sensenich, *loc. cit.*, Part 2, p. 558.

are bitterly and unalterably opposed to Government-controlled medicine.⁴⁷

These voluntary plans keep faith with the democratic principles of our American form of government as well as preserving the American system of private practice of medicine, which is essential to the welfare of patients—the American public.

We urge that the Federal Government give support and encouragement to these voluntary plans, which if given time, will furnish the objectives of this bill without jeopardizing the system of medical care, which has made this Nation foremost in health, and without compulsion and regimentation.⁴⁸

Voluntary plans, it was said, are meeting different needs in different localities and of different groups. A compulsory system will prevent necessary experiments with state and local plans and will thus interfere with sound developments.

Do Other Things First. There are many things that need to be done to improve medical care for the people, and it was argued that those things should be done before compulsory health insurance is undertaken.

If Government is sincerely interested in the health of the citizen, why should it not suppress patent-medicine advertising? Why should it not regulate the cults, and require that all who wish to practice the healing arts pass the same tests? Why should it not control radio publicity of nostrums, vitamins, and the like? This current legislation is attacking only a small segment of the health problem, and even if it were to accomplish all that its proponents claim, it still would not solve our health problems.⁴⁹

Political Medicine and Socialization. On the political aspects of health insurance, there was engendered more heat than light, especially by representatives of the American Medical Association, ably assisted by representatives of the American Bar Association.

No one will ever convince the physicians of the United States that the Wagner-Murray-Dingell bill is not socialized medicine. By this measure the medical profession and the sick whom they treat will be directly under political control. By this measure the great system of private hospitals and community hospitals that have grown up in our country will depend

⁴⁷ Dr. Lowell S. Goin, *loc. cit.*, Part 2, pp. 623, 627.

⁴⁸ Dr. Harold T. Low, *loc. cit.*, Part 2, pp. 796, 803.

⁴⁹ Arthur Lewis Miller, Representative in Congress from Nebraska, *loc. cit.*, Part 3, pp. 1850–1851.

for their continued operation on the funds paid to them by a Federal Government agency. By this measure the philanthropic efforts for the care of the sick, which have been the pride of our Nation, will forever be deterred. Through this measure competent young men who would enter the medical profession will be forced to seek other fields of action still remaining under our democracy which still permits the exercise of individual initiative and freedom of thought and action. By this measure doctors in America would become clock watchers and slaves of the system. Now, if ever, those who believe in the American democracy must make their belief known to their representatives, so that the attempt to enslave medicine as first among the professions, industries and trades to be socialized will meet the ignominious defeat it deserves.⁵⁰

Samuel Gompers, whose views on the subject are no longer held by organized labor, was quoted as follows:

The introduction of compulsory social insurance in cases of sickness, or compulsory social insurance in cases of unemployment, means that the workers must be subject to examinations, investigations, regulations and limitations. Their activities must be regulated in accordance with the standards set by governmental agencies. To that we shall not stand idly by and give our assent.⁵¹

An extreme stand was taken by Mr. Fred Bailey, legislative counsel for the National Grange. He said: "Compulsory medical insurance is as un-American as the Gestapo."⁵²

Reduction in the Standard of Medical Care. Representatives of the organized medical profession generally believe that compulsory health insurance will actually lower the standard of medical care available to the people. Government administration would inevitably be incompetent, inefficient, bureaucratic, and political. It was said that:

Doctors agreeing to participate in this compulsory, socialized medical system would be subject to the dictates, rules, regulations, and red tape imposed upon them by bureaucratic control. They would constantly be at the mercy of lay control, political appointees, subject to the complaints of disgruntled patients as well as persistent demands from malingerers seeking certification of illness. Doctors, like all people, are human, mortal and frail, and under the continued high pressure of patients, who would want their tax money's worth whether sick or not, and the depressing influence

⁵⁰ From an editorial in the *Journal of the American Medical Association*, December 1, 1945, quoted in *loc. cit.*, Part 2, p. 552.

⁵¹ *Loc. cit.*, Part 2, p. 867.

⁵² *Loc. cit.*, Part 3, p. 1644.

of directives, they would lose all initiative, and with the incentive lacking, become mere cogs in the system of socialized medicine. Deterioration of medical care would be the inevitable result⁵³

Under compulsory insurance . . . there is a tendency on the part of too many people to "enjoy" a long illness, to run to a physician with every small or imaginary illness. Some physicians, with fees based on the number of calls, or patients seen, would yield to temptation to profiteer, both at the public expense and at the expense of other patients, who might have a more legitimate claim on their time.⁵⁴

I think it quite interesting to note that compulsory health insurance has been in effect in San Francisco for some years as regards the municipal employees. The insured are served by the same physicians and in the same hospitals as are noninsured persons. In spite of the fact that no financial barrier exists between an insured person and a physician, the incidence of ruptured appendix is higher among the insured than among the noninsured. In this instance, at least, the removal of the financial barrier, so abhorred of the social planner, did not seem to benefit the insured public.⁵⁵

Many references were made to European experience with compulsory health insurance. Dr. Nathan Sinai, who favored compulsory health insurance, pointed out in his book *The Way of Health Insurance*, that "contrary to predictions, the most startling thing about the vital statistics for insurance countries is the steady and fairly rapid rate of increase in the number of days the average person is sick annually, and the continuously increasing duration of sickness." The average number of days sickness among insured persons is said to have practically doubled in Germany and Britain since the installation of health insurance.⁵⁶ Speaking of the English system, one doctor said:

There is a fundamental human inclination to demand everything that they are entitled to whether they need it or not. The result is again overcrowding, superficial examinations, erroneous snap diagnoses, unnecessary and incorrect treatment, lack of personal interest and from continually repeated habit, a lowered standard of medical care which is frankly admitted by many. And what is more ominous for the future, the press of

⁵³ Offered as evidence was the breakdown of medical care for veterans in the previous war, which almost resulted in a national scandal. Dr. Harold T. Low, *loc cit.*, Part 2, p. 802. See also Dr. Mary B. Spahr, "A Doctor Looks at State Medicine," *Saturday Evening Post*, July 21, 1945, pp. 14-15.

⁵⁴ Fred Bailey, *loc cit.*, Part 2, p. 1643.

⁵⁵ Dr. Lowell S. Gorn, *loc cit.*, Part 2, p. 626.

⁵⁶ *Loc. cit.*, Part 2, p. 626.

work robs the physician of his required study, reading and thought, so that instead of improving efficiency by experience, there is a constant deterioration of his ability, and what is of basic importance, a growing disinclination to be concerned with his patient's welfare.⁵⁷

This diabolical scheme of increased grandeur to the great and further abjection in slavery to the slaves, was first set up by Bismarck in 1888. . . . The same plan of social security was adopted in 1893. Up to that time Germany and Austria were the Meccas for us all, as they led the world in medical progress and science, but under such regimentation and attempted direction of thought and throttling of ambition to the oblivion of imagination, these countries year by year lost their high positions in the world of science and progress.⁵⁸

Another member of the medical profession had something to say about preventive medicine.

Too much confidence is placed in preventive medicine; too much earnest belief that periodic health examinations will prevent disease, and all the legislation evidences a complete failure to understand that preventive medicine has not yet attained the goals wished for.⁵⁹

Medicine needs the best young men and women for training in the healing arts and if a compulsory service is provided these persons will not be attracted to medicine because of the lack of opportunity to attain eminence and affluence in the profession.⁶⁰

Personal Relationships. A great deal was said about the effect of compulsory insurance on the personal relationship between doctor and patient. Much of it was superficial, penetrating no deeper than to the "friendly" interest involved. But some of it touched on important matters.

It would seem to me that at ever so many steps in the contact between patient and physician, there would be injected into the patient-physician relationship, extraneous considerations of the most diverse kinds. The physician would be expected to make reports to his government; to maintain records quite different from the case histories which he now maintains and which would be prescribed for him; he would lose a great deal of contact with his patients through the fact that he receives a stipulated sum from Government sources. Since he is being paid on a service basis and on the basis of a fee schedule, he would be bound to lose the proper

⁵⁷ Dr. Walter V. Kennedy, *loc. cit.*, Part 2, p. 706.

⁵⁸ Dr. Charles Scott Venable, "Socialized Medicine Shall Not Pass," *Texas State Journal of Medicine*, June 1944, pp. 49-52.

⁵⁹ Dr. Lowell S. Goin, *loc. cit.*, Part 2, p. 627.

⁶⁰ Dr. John W. Green, *loc. cit.*, Part 1, pp. 541-542.

attitude toward professional remuneration which in any true concept of medical care is regarded only as a token payment and not in any sense as a wage or salary or stipend but only as an honorarium. All of these consequences would be found to follow as I see it and from all of them, there would also necessarily be bound to result a deterioration in the character of medical practice. There would almost of necessity be a commercialization and the material outlook upon practice which would thus be fostered might actually result in serious consequences to the whole concept of medical care for American people.⁶¹

The personal relationships of friendliness, genuine interest, coöperation, and mutual liking and respect are important and contribute immeasurably to good medical care, but they are of very minor importance as compared with the "fiduciary" relationship, which the courts for centuries have recognized as the central fact in the doctor-patient relationship, and which is negated by almost every provision regarding medical care.⁶²

It was pointed out that a doctor accepting a patient's "trust" in him acts in the patient's behalf in treating him. The implied agreement has common-law recognition, and statutory recognition in some states. Violation of that trust is malpractice and subjects a doctor to liabilities for damages.⁶³

Freedom of choice, it was argued, would be practically nonexistent, for either patient or doctor. And the argument was pressed vigorously.

Proponents of this bill have made the statement that free choice is provided in the measure. This is not true. It is limited free choice with all of the destructive eventualities this limitation could impose.

It is free choice only of the doctors who are willing to serve under this scheme, which in their opinion, would result in the deterioration of the quality of medical care administered. . . .

It is not free choice because the bill provides that the Surgeon General can limit the number of patients that a physician may see, and he is permitted to provide other physicians when, in his opinion, too many patients select the same physician.

⁶¹ The Rev Alphonse H Schwitalia, *loc. cit.*, Part 3, p. 1797. The executive secretary of the National Wholesale Druggists' Association is reported to have said: "Fifteen years ago only twenty-five percent of prescriptions were for manufactured specialties. Latest figures from a private survey of more than 13,000 prescriptions in sixty-seven typical drug stores in the Mid-west indicate this percentage had increased to fifty percent." A. P. news item, *Kansas City Times*, February 20, 1947.

⁶² Dr. Frederic B. Exner, *loc. cit.*, Part 2, p. 814.

⁶³ *Ibid.*, p. 815.

Further, it is not free choice unless the physician is willing to work under the plan of payment of services, which plan and amount of remuneration are set by the Government.⁶⁴

We will take a community where there are five doctors who go into this governmental plan. There are 5000 people in the community, who would come under the plan. The most popular of those five doctors would be rather promptly selected by many of the people in that group. Suppose that they would select the doctor to the extent of the maximum number of potential beneficiaries prescribed by the Surgeon General. Then suppose you or I, living in that community, should come to that particular physician and desire treatment from him. He would respond that his quota was already filled. Would you not agree that in that case, whether it is an exceptional one or not, that in that particular illustration there would be a restriction on your choice and mine?⁶⁵

The Public Does Not Want a Compulsory System. A poll was taken by the Opinion Research Corporation for the National Physicians Committee in 1943.⁶⁶ More than three-fourths of those polled believed that "something could be done to make it easier for people to pay for doctor and hospital care." A poll taken in 1945 showed even more were of that opinion. More than half of the people polled admitted having experienced some hardship in meeting medical bills. An overwhelming majority were in favor of a prepayment system.

But a majority of those polled were not in favor of a government-sponsored prepayment plan. Only 34 percent preferred a government-sponsored plan for themselves; 39 percent preferred group insurance; and only 12 percent preferred a doctor-organization plan. Forty-two percent believed that a government plan would involve too much red tape and political influence, 23 percent believed that it would curtail their freedom to select a doctor, and 22 percent believed that doctors would take less personal interest in their patients.

It is true that some polls show a majority in favor of compulsory health insurance. But the majorities are too small to be significant. The National Opinion Research Center of the University of Denver made a survey in August 1944.⁶⁷ Only 51 percent of those with opinions on the subject favored compulsory health insurance bills

⁶⁴ Dr. Harold T. Low, *loc. cit.*, Part 2, p. 797.

⁶⁵ Senator Forrest C. Donnell, Committee on Education and Labor, *loc. cit.*, Part 1, p. 481.

⁶⁶ *Loc. cit.*, Part 1, pp. 72-78.

⁶⁷ *Ibid.*, pp. 66-69.

then under consideration. A poll taken in 1945 by the New York State Commission on Medical Care showed that only 51.9 percent preferred a government plan, and New York has a larger proportion of foreigners and radicals than the country as a whole.⁶⁸

The polls indicate that public opinion on compulsory medical care insurance is still in process of being formed. It would be unwise, so the argument ran, to take any action until that opinion has become crystallized.

Divine Healing. There are approximately forty religious denominations in the United States whose members, numbering in the millions, believe in divine healing and who do not use medicine or medical treatment. They oppose compulsory health insurance on the grounds that it is ineffective, that it requires them to pay for something they do not use or believe in, that it interferes with their freedom of religion, and that it is totalitarian and despotic. The argument was ably presented by Arthur J. Todd, manager, Christian Science Committee on Publications, and emeritus professor of Sociology at Northwestern University. He said:

If the bill would greatly improve the health of the great majority who rely on medical treatment, we should certainly not object to its passage. . . . We believe that Government medical care, combined with cash payment during sickness, would have the same tendency here as elsewhere to prolong sickness, to produce an inferior quality of medical care, and to lead many people to seek medical service when they did not really need it simply because they could get it without further expense. . . . If, as we insist, healing is an integral part of a religious faith and practice, any attempt to fasten upon this country a compulsory tax-supported system of health insurance is an interference with that freedom of religion guaranteed by the Bill of Rights. It in no wise clears away this obvious illegality to assert . . . that nobody will be compelled to accept medical, surgical, hospital, or nursing services contemplated. . . . The requirement to pay taxes violates constitutional protection of religious freedom no less than would universal requirement to submit to compulsory medicine or hospitalization or emperor worship. . . . Christian Scientists urge you to beware of this latest form of a benevolent despotism which we had hoped our forefathers swept away a century and a half ago. . . . We come before this committee not as opposing any system of medicine or surgery or health regimen. We do not desire to impose our way of thought or healing upon anybody. We believe in voluntary acceptance or rejection of po-

⁶⁸ *Ibid*, pp 70-72.

litical, religious, or medical beliefs. . . . We simply ask that we be permitted to enjoy the same freedom which, as American citizens, supporting the American way of life, we are trying to sustain for others.⁶⁹

Quackery. One argument, made by a prominent physician, was that a compulsory system will result in the development of medical "quacks."

Another serious defect of socialized medicine is that it encourages quackery. Four years after compulsory health insurance was adopted in Germany there were 1713 lay practitioners, "charlatans" and "quacks" in Germany, and in 1929, the last statistics I have been able to get, there were 12,413. Germany has been called the "happy hunting ground for quacks." There is a belief deep-seated in the human mind that the thing which you can get for nothing is worth nothing. This accounts for the fact that many of the members of the Krankenkasse value the services of their physicians lightly and spend huge sums in running to "quacks" and in buying all sorts of patent medicines. . . . While studying in Hamburg I was told by a number of the medical men that it was a very common practice for Krankenkasse patients to go to a panel physician principally to get sick benefit allowance and step right out of the office, throw away the prescription the doctor had given them, and go directly to the office of a "quack" for advice. One of the very worst features in any and every form of compulsory health insurance so far devised, or, as I believe, can be devised, is that it unquestionably lowers the confidence both of the individual and the public in the efficiency and the integrity of the medical profession.⁷⁰

THE AMERICAN MEDICAL ASSOCIATION

Because it is so highly representative of the profession and because it is almost unanimously opposed to compulsory legislation on prepayment medical care, something more should be said about the American Medical Association, its major tactics, and its official program.

The American Medical Association has a membership exceeding 125,000 and includes nearly all of the practicing physicians in the United States. The only other general professional organization of practicing physicians is the National Medical Association, consisting of about 4000 Negro physicians, although there are many organizations of specialists. There is little doubt that official policies and

⁶⁹ *Loc. cit.*, Part 4, pp. 1916-1919.

⁷⁰ Dr. Edward H. Ochsner, *loc. cit.*, Part 4, p. 2161.

statements of the American Medical Association represent accurately the views of a substantial majority of the medical profession in the United States.⁷¹

Neither the American Medical Association nor its component parts were much interested in prepayment medical care plans until quite recently. For many years the profession generally has been either lukewarm or hostile to any kind of prepayment plan.

In 1919 a committee of the Association issued statements favorable to compulsory health insurance. But in 1920 the House of Delegates came out in opposition. In 1932, a minority report of the Committee on the Costs of Medical Care, the minority consisting mainly of representatives of the A.M.A., was opposed to both voluntary and compulsory insurance, but said that if they had to choose between the two they would choose compulsory insurance. The House of Delegates approved the minority report. That should not be interpreted to mean that the American Medical Association really favored compulsory insurance, but rather that at the time a compulsory system appeared to be more logical than a voluntary one. Perhaps the House of Delegates was also influenced by the thought that the American people would at that time be strongly opposed to a compulsory system and that by taking the position it did the profession could best stave off both systems.

In its struggle against compulsory health insurance, the Association has used what may be called delaying tactics. Dr. Morris Fishbein, its colorful secretary, praised "the delaying tactics that have been a feature of the policies adopted by the House of Delegates of the American Medical Association."⁷²

One method used has been to urge that voluntary plans be tried first, and to participate in the development of the voluntary movement. Through its component parts, the state medical societies, the Association has established and operates voluntary prepayment medical care plans. Small scale experiments were carried on as far back as 1925, but the movement really got under way about 1940 and has spread fairly rapidly since then. The Association's Council on Med-

⁷¹ But see statement by Senator J. Howard McGrath, in United States Senate, *Hearings Before a Subcommittee of the Committee on Labor and Public Welfare on S. 545 and S. 1320*, 80th Congress, 1st Sess., 1947, Part 3, pp. 1515-1535, where he gives reasons for believing that "the A.M.A. does not honestly represent the doctors of America. . . ."

⁷² Quoted in *Hearings on S. 1606*, Part 1, p. 81.

ical Service and Public Relations, Division of Prepayment Medical Care Plans, encourages and assists the organization and development of such plans. Capitalizing on those developments, one representative spoke as follows:

Recently . . . the medical profession has realized the importance and force (of the movement for health insurance and has been) promoting a compromise in the form of voluntary prepaid medical care under the control of physicians. This may not be the best compromise, and may not even prove satisfactory, but it represents the first step by either side toward a solution of the dilemma, and I believe it should be given a full trial before being dismissed as unsatisfactory. In any case, the fact that the first attempt at a realistic compromise has come from the doctors would seem to indicate that it is easier to teach economics to doctors than to teach the facts of life regarding medical practice to economists, sociologists, and idealistic reformers.⁷³

It is worth while to record here another proposal, coming from a staunch supporter of compulsory health insurance, that, if adopted, might well also have the effect of delaying the movement.

Now what I want to stress is that the [Wagner-Murray-Dingell] bill makes it very clear that States should be able to qualify by presenting a plan containing sufficient medical and surgical personnel, and States should be also able to divide their territory, because it will take several years before some States and parts of States will be able to provide the necessary medical talent. It just does not exist today. You have an opportunity to get a splendid start here by taking it in localities where they are able to give the service because it would be manifestly unfair to make a charge and not be able to give the proper kind of service. . . . It will take a few years to build and get this thing started, but I want to start it right.⁷⁴

Another method of delaying compulsory health insurance used by the American Medical Association has been to play up the weaknesses of foreign systems. The attack has been bitter, frequently vicious, and sometimes wholly unwarranted. Evidence used has sometimes been anything but scientific.

The Honorable John D. Dingell, co-sponsor of the Wagner-Murray-Dingell bill, accused the American Medical Association and its "satellite" organization, the National Physicians Committee, of "lay,

⁷³ Dr. Frederic B. Exner, *loc. cit.*, Part 2, p. 814

⁷⁴ Fiorello LaGuardia, *loc. cit.*, Part 1, pp. 291-298.

ing down a deadly barrage of baseless propaganda for the sole purpose of creating fear and confusion among the American people. The object of this campaign is to perpetuate a system which is as selfish as it is deficient if it is not altogether outmoded.”⁷⁵

The American Medical Association published a pamphlet on the English health insurance system. One secretary of the British Medical Association said about that pamphlet that it “contains only a succession of distorted and confused facts and a partisan selection of opinions. . . . Almost every page of the pamphlet provides matter for criticism on the score of inaccuracy or unfair presentation.”⁷⁶ The chairman of the Board of Trustees of the American Medical Association tried to pass off the criticism by saying that it was made by a secretary who had since died and that the new secretary of the British Medical Association “has issued a statement to the effect that the presently proposed expansion of compulsory sickness insurance in England will be opposed by the medical profession, since the proposals would lead sooner rather than later to doctors becoming whole-time salaried servants of the state.”⁷⁷

It was true that some of the new proposals were being opposed by the British medical profession, but the profession was not opposing the existing general system of health insurance. The new Secretary of the British Medical Association made that clear. He wrote:

We know that the system is by no means perfect and that it has some serious defects, more especially the absence of provisions for the dependents of insured persons and the exclusion of consultant and specialist treatment. But on the whole, and so far as it goes, it is a good scheme and works well, and the British doctors have a right to expect that when a writer takes it upon himself to describe the scheme to the profession in another country he will make some effort to verify his facts⁷⁸

The British Medical Association is opposed to certain drastic features of the Beveridge plan and its members at one time voted against even entering negotiations with the Labor Government to take part in making regulations to govern medical and allied services under the new plan. However, it should be recorded that 45

⁷⁵ *Loc. cit.*, Part 1, p. 64

⁷⁶ Quoted by Senator Robert F. Wagner, *loc. cit.*, Part 1, p. 66.

⁷⁷ Dr. R. L. Sensenich, *loc. cit.*, Part 2, p. 557.

⁷⁸ Letter from Dr. Charles Hill to the American Medical Association, in *Journal of the American Medical Association*, vol. 130, No. 11, March 16, 1946, reprinted in *loc. cit.*, Part 2, pp. 717-718

percent of the members voted in favor of entering negotiations.⁷⁹ Later the Association decided that "diplomacy rather than brute force was indicated" and voted by an overwhelming majority to enter negotiations, although as a body it was still opposed to the proposed act as it stood.⁸⁰ Subsequently, and by an overwhelming majority, the profession voted not to coöperate in the new plan. But just before the date on which the new system became effective, and after certain assurances had been given, the profession voted to participate in the program.

A ten-point national health program of its own which it considers to be far better and more practicable than any compulsory system has been offered by the American Medical Association.⁸¹ The plan may be outlined as follows:

1. A minimum standard of nutrition, housing, clothing, and recreation is fundamental to good health. It is the individual's primary responsibility to provide himself with this minimum standard. Where for good reasons it is not possible for the individual to provide that minimum for himself, then "community effort" may be applied and any needed aid should be given. But community effort and government aid should be strictly compatible with the maintenance of free enterprise.

2. Preventive medical services are also fundamental to a national health program. These services should be centered in health departments headed by professional personnel and adequately staffed and equipped. Federal funds or personnel may be used to establish and operate these departments, but local areas must maintain control. Health departments should not care for the sick, not even the medically indigent. The poor should be treated by physicians of their choice and medical and hospital costs should be paid with funds provided by local agencies subsidized, if necessary, by the Federal government.

3. Maternal and child care should be made available to all "at a price that they can afford to pay." Local funds should be used if necessary, and Federal aid should be provided when state and local funds are inadequate. But aid of this kind should be administered through state and local agencies.

⁷⁹ Associated Press news report, *Kansas City Times*, December 13, 1946.

⁸⁰ *Journal of the American Medical Association*, March 15, 1947, p. 797.

⁸¹ *Hearings on S. 1606*, Part 2, pp. 553-554.

4. Children, throughout infancy, should have "proper attention including scientific nutrition, immunization against preventable disease and other services included in infant welfare." This should be achieved preferably by personal contact between the mother and the individual physician, but it may also be done through welfare stations administered locally and tax supported if necessary.

5. Health and diagnostic centers and hospitals must be provided. These should be supplied by local agencies such as community, church, and trade, that have traditionally been responsible for them. But if local and state agencies cannot supply such facilities where they are actually needed, then the Federal government should provide aid, but on condition that the local community prove its ability to maintain them once they are established.

6. Voluntary nonprofit prepayment plans for medical care and hospitalization, such as Blue Cross and medical society plans, are essential in a national health program. But the principles of medical care plans should be acceptable to the American Medical Association's Council on Medical Service and authoritative state medical associations. Private medical care plans are permissible as part of the evolutionary process if they "comply with State regulatory statutes and meet the standards of the Council on Medical Service of the American Medical Association."

7. Medical care and hospitalization for veterans should be provided. The medical care should be given by physicians chosen by veterans and payment should be made in accordance with some plan mutually agreed on between the state medical society and the Veterans' Administration.

8. "Research for the advancement of medical science is fundamental in any national health program." A national science foundation supported by the Federal Government is approved.

9. Volunteer philanthropic agencies such as the American Cancer Society, the National Tuberculosis Association, The National Foundation for Infantile Paralysis, Inc., the Commonwealth Fund, and the Rockefeller Foundation are of vast benefit in a national health program and they should be encouraged to participate in such a program. They "are a natural growth of the system of free enterprise and democracy that prevail in the United States."

10. Health education and the dissemination of health information by authoritative agencies are fundamental to the promotion of public health and the alleviation of illness. "Health education should be

considered a necessary function of all departments of public health, medical associations, and school authorities."

The American Medical Association's program here outlined has been characterized as "a collection of pious hopes and feeble generalizations."⁸² That may well be too harsh a judgment. But it does not seem unfair to say that the American Medical Association in its proposed national health program offers what the public already has in a measure and does not object to a bit more of the same, provided that bit more conforms to its principles and standards and, wherever possible, is subject to its control.

THE BROOKINGS REPORT

The chairman of the Senate Committee on Labor and Public Welfare requested the Brookings Institution to study the issues of compulsory health insurance. Dr. Lewis Meriam and Dr. George W. Bachman, aided by a committee of staff members, made the study and reported their conclusions and recommendations.⁸³ The conclusions are not very different from those reached in 1932 by the Committee on the Costs of Medical Care. Because the report still carries some weight in the controversy, brief summaries of the conclusions and recommendations will be given.

Conclusions. It was concluded that the health of our white population is probably as good or better than that of whites in any other great nation, that the materially poorer health of nonwhites cannot be traced primarily or mainly to inadequate medical care, that selective service data are unreliable as a measure of the nation's health, that we have made greater progress in medical and sanitary science than any other country, that our medical care compares favorably with that of leading European nations before the second World War, and that no basic defects are suggested in our system.

Most American families are able to pay for their medical care, if only they are willing to give the need a high priority. There are medical indigents, mostly old and disabled men and women and widows or deserted women and their dependents, who must be assisted and for whom an insurance system would do no good. Subsidies cannot solve the public health problems of poor rural areas,

⁸² Andrew J. Biemiller, *Congressional Record*, October 25, 1945.

⁸³ George W. Bachman and Lewis Meriam, *The Issue of Compulsory Health Insurance*, The Brookings Institution, Washington, 1948.

which should have new or improved economic activities brought in or their people moved out.

Compulsory health insurance would result in much difficult government control over medical personnel and agencies, and it is doubtful that initiative and development would thereby be encouraged. Defects revealed through operations would probably be remedied by increasing government controls. It would be difficult to keep the program out of politics, and government might well damage the physician-patient relationship and impair the quality of medical care. Thousands of government employees would be needed to administer such a system.

Recommendations. It was recommended that for the present the Federal government leave to the states the matter of establishing or not establishing compulsory health insurance systems. In some states, voluntary arrangements will prove to be fairly satisfactory. If local experimentation with health insurance yields a pattern that will fit most of the country, which is not likely, national adoption with much unanimity will surely follow. But a pattern established by a small majority vote and imposed on the entire country will have to operate in a hostile environment.

The national government and state governments may legitimately and profitably use their resources and energies in the field of public health, in school health education programs, in the teaching of preventive medicine, in providing physical health facilities and in training health personnel, and in "providing systematic care for the indigent and the medically indigent."

Health depends in part upon nonmedical factors such as food, shelter, vice and crime, transportation, and industry, as well as upon the intelligent coöperation of individuals and communities. Adult educational campaigns for the control and prevention of disease should be left altogether to voluntary organizations. Such organizations can secure the willing coöperation of leading laymen in all communities.

CHAPTER TWENTY

HOSPITAL SERVICE PLANS

HOSPITALS are particularly important, and increasingly so, in any scheme or system of medical service. The number of hospitals registered by the American Medical Association declined from 6807 in 1927 to 6665 in 1952, but the number of beds increased from 853,318 to 1,541,615, while the number of admissions increased from 7,155,976 in 1931 to 18,914,847 in 1952.¹ The average daily census in 1952 was 1,309,377 and the number of patient days was 479,231,982.

Maternity cases treated in registered hospitals have increased greatly, from 708,889 in 1931 to 3,170,495 in 1952.² The most serious cases of illness and injury can best be treated in hospitals. Hospitals are steadily becoming more important also as centers in which advanced diagnostic equipment and services are concentrated, and it is becoming more and more common to hospitalize doubtful cases for purposes of observation. Furthermore, hospitals are being used to an increasing extent as research and teaching institutions. It has long been recognized that "where hospital facilities are missing, medical progress lags."³ Finally, hospitals are becoming increasingly important as centers for medical social work.⁴ It might be added that the modern hospital is becoming the focal point of a larger unit known as a medical center.

The cost of hospitalization has always been a significant deterrent to its most effective utilization, especially to the lower-income groups, and has imposed heavy financial burdens on many of those who were unfortunate enough to need hospitalization and fortunate

¹ *Journal of the American Medical Association*.

² *Ibid.*

³ Henry J. Southmayd and Geddes Smith, *Small Community Hospitals*, The Commonwealth Fund, 1944, p. 3.

⁴ Arthur C. Bachmeyer and Gerhard Hartman, *The Hospital in Modern Society*, The Commonwealth Fund, 1943. Florence Taub, "Not For the Indigent Alone," *The Modern Hospital*, August 1947, pp. 62-64

enough to be able to pay for it. On the other hand, hospitals generally find themselves compelled, either by law or by tradition, to provide considerable free hospitalization, and in a great many instances have been unable to collect any or all of the charges incurred by patients able to pay. Despite the fact that "the modern community hospital under voluntary auspices is a middle-of-the-road merger of the charity institution and a private facility,"⁵ heavily subsidized by philanthropy and taxation, general hospitals have found it difficult to meet their expenses. In the absence of a nonprofit insurance plan, hospital rates represent a rough balance between "what it costs the hospital to give service of the quality it feels obligated to maintain, what the patient thinks he can pay; what the hospital thinks the patient can pay; and what the hospital thinks the community will pay."⁶

NONPROFIT PLANS

Hospital care insurance of some kind has long been indicated as an answer, in part at least, for patients and hospitals, as well as for communities. Such insurance, in the form of nonprofit group hospital service plans, constitutes one of the most significant of recent developments in the field of medical care. This movement is unique, historically and geographically, for its counterpart has not existed elsewhere. The plans are, as one authority on them has said, "a form of public service without public compulsion, an example of private initiative without private gain. They combine the American practice of personal action with a sense of social responsibility."⁷ Voluntary insurance of this type has received the endorsement of all professional medical associations, has been sponsored and guided by the American Hospital Association, and has been endorsed by all leading labor and farm organizations. The movement was developed primarily by hospitals and has remained a producers' rather than a consumers' movement.

The purpose of this type of insurance is simply to enable individuals to budget the cost of possible hospitalization. But it does not favor lower-income groups with lower rates for equal service, and

⁵ Southmayd and Smith, *op. cit.*, p. 3.

⁶ *Ibid.*, p. 83.

⁷ C. Rufus Rorem, *Community Hospital and Medical Plans*, American Hospital Association, 1944, p. 16.

strictly speaking is not "social" insurance. Plans for lower-income groups may, to be sure, provide less in the way of service and thus have relatively low rates. But social insurance principles are not incorporated into the plans.

Historical Background. One of the oldest large and continuous nonprofit hospital service plans in the United States is that established by Baylor University Hospital, Dallas, Texas, late in 1929, when for \$3 per person per semester it offered a maximum of 21 days of hospitalization in semiprivate rooms, plus operating room, laboratory services, drugs and dressings, and other services, to 1500 local schoolteachers. Later other groups were admitted and rate variations were made on the basis of occupation and services desired. Although it was by no means the first, the Baylor University plan is credited by many as being the immediate forerunner of the modern movement.⁸

There has been a marked growth in the number of hospital plans and a phenomenal increase in the number of persons covered. It has been estimated that by July 1, 1936, there were 33 plans with 370,000 participants. On January 1, 1940, there were 60 plans with about 4.5 million members. Growth since 1940 has been nothing short of spectacular. By January 1, 1954, the number enrolled was over 46 million, and there were 85 plans.

The cancellation rate was rather high during the war years owing to high labor turnover. Before the war, the average was about 10 percent. For 1945-1946, a period of marked readjustments, the rate was 17.1. Since then it has approached the prewar rate.⁹

There is every reason to believe that expansion in the number of participants will continue to be substantial for some years to come. The number of plans established has become pretty well stabilized.

Membership. Table 66 shows the growth in number of Blue Cross plans and members enrolled since 1933. The Blue Cross system is a grouping of nonprofit prepaid hospital plans and will be

⁸ For a brief description of the early movement, see J. T. Richardson, *The Origin and Development of Group Hospitalization in the United States, 1890-1940*, University of Missouri Studies, vol. xx, No. 3, 1945, Louis S. Reed, *Blue Cross and Medical Service Plans*, Federal Security Agency, U.S. Public Health Service, 1947, chap. 2.

⁹ Louis S. Reed, *Blue Cross and Medical Service Plans*, chap. 11.

described later in this chapter.¹⁰ In addition to these plans and members, there are others, relatively few in number, that for some reason are not a part of the Blue Cross system.

TABLE 66. Blue Cross Hospital Service Plans, Number and Enrollment, January 1, 1933, to January 1, 1948, and 1954¹¹

Year	Number of Plans	Enrollment (Round Numbers)
1933	1	2,000
1934	6	11,500
1935	10	54,000
1936	17	214,300
1937	26	608,400
1938	54	1,365,000
1939	65	2,870,000
1940	71	4,431,700
1941	73	6,049,200
1942	77	8,456,300
1943	77	10,458,900
1944	76	13,005,500
1945	85	16,500,000
1946	87	20,000,000
1947	87	25,876,000
1948	90	29,499,000
1954	85	46,141,000

Membership is heavily concentrated in metropolitan areas and industrialized states, where there are well organized and equipped voluntary hospitals and where average per capita income is relatively high. The distribution given below of more than 45 million participants in 86 plans as of September 30, 1953, according to size of plan, shows that concentration.¹² Plans with 1 million or more members were in New York, Massachusetts, Illinois, Michigan,

¹⁰ The Blue Cross symbol was developed by the St. Paul, Minnesota plan. Louis S. Reed, *op cit*, p. 11.

¹¹ Taken from Sinai, Anderson, and Dollar, *Health Insurance in the United States*, The Commonwealth Fund, 1946, p. 44, Blue Cross Commission, *Financial Reports, Blue Cross Plans, 1948*, American Hospital Association. On January 1, 1947, there were 1,593,251 Blue Cross members in Canada and 33,090 in Puerto Rico, included in the total given here. As of June 30, 1948, enrollment totaled 31,210,819, of which 2,194,739 were in Canada and 43,459 were in Puerto Rico. The Canadian membership is likely to decline as compulsory provincial plans are established.

¹² *Financial Reports, Blue Cross Plans, 1946, Enrollment Reports, First Nine Months, 1953.*

Pennsylvania, and New Jersey. More than half of the smallest plans, those with less than 50,000, were in Southern states.

Number of Plans	Size of Class	Participants	
		Number	Percent
11	1,000,000 or more	23,448,119	51.5
14	500,000 to 1,000,000	9,656,728	21.2
30	200,000 to 500,000	9,870,793	21.7
9	100,000 to 200,000	1,300,754	2.9
12	50,000 to 100,000	955,493	2.1
10	Less than 50,000	273,731	0.6

Many plans are state-wide and those in populous states would naturally have more participants. The degree of concentration is further indicated by the data given below showing the percentages of total population enrolled as of July 1, 1954, by states.¹³ Only a few nonindustrial states had as much as 30 percent of their total

State	Per- centage	State	Per- centage
Rhode Island	70.7	Oklahoma	18.1
District of Columbia	67.9	North Carolina	17.7
Delaware	62.2	Nebraska	17.1
New Hampshire	59.4	Arizona	15.9
New York	50.6	Virginia	15.8
Pennsylvania	48.6	Kentucky	15.1
Michigan	45.6	North Dakota	14.9
Massachusetts	43.8	Montana	14.1
Ohio	43.5	Utah	14.0
New Jersey	35.8	Florida	13.3
Maryland	34.2	Mississippi	12.0
Colorado	33.7	West Virginia	11.2
Maine	33.4	Louisiana	10.5
Minnesota	32.8	South Carolina	10.0
Wyoming	32.8	Texas	9.9
Missouri	28.9	California	9.7
Iowa	27.7	Oregon	9.2
Indiana	26.5	Idaho	8.3
Wisconsin	25.7	Arkansas	8.1
Illinois	22.7	Georgia	7.3
Kansas	22.1	Washington	5.1
Tennessee	21.3	New Mexico	4.8
Alabama	18.1		

¹³ The population figures used are estimates as of July 1954.

population enrolled. It is difficult to reach rural areas, but some progress is being made by working with farm organizations and by community enrollment programs.

The percentage of the total population for the United States as a whole covered by Blue Cross plans was about 30 in 1953. That represents a marked increase over the percentage in 1947, which was only 17. In 1953, 41 percent of the total enrollment consisted of subscribers, and 59 percent of their dependents. Only 46 percent were dependents in 1947. Two states with hospital plans were not affiliated with the Blue Cross movement in 1953.

Growth in membership has been spectacular, and there is no doubt that enrollment will continue to expand for some years to come. Intensive promotional efforts continue to be made, and the backlog of good will which has been built up in the past will provide a tremendous forward momentum. The expansion in hospital facilities which is now taking place and which will continue is another factor favorable to expansion. There is still another, less tangible, factor which is making for expansion. Pressure to include hospitalization benefits in Federal legislation is helping to solidify the ranks of those who favor the voluntary movement, and to lead them to greater efforts.

However, there are certain factors which may act as a brake on the further expansion of membership. For one thing, areas not already well worked are likely to yield lower returns in terms of membership for the same amount of promotional effort. Much of the cream has been skimmed off the market. Higher hospital costs and greater benefits being offered necessarily lead to higher premium rates to members, and this will tend to discourage enrollment, even though the rise in premiums is relatively less than the rise in the general price and wage levels. It should not be so, but when the financial shoe begins to pinch, necessities are among the first to suffer. The increase in premiums will also probably intensify the competition of commercial insurance carriers that sell hospital indemnity policies, a competition which is already being felt.¹⁴ The

¹⁴ See United States Senate, *National Health Program, Hearings Before a Subcommittee on Labor and Public Welfare on S. 545 and S. 1320*, 80th Congress, 1st Sess., Part 1, pp. 419-420, where Senator Murray said that 16 independent railroad organizations on the Boston & Maine recommended discontinuance of Blue Cross hospital and medical coverage because it could be purchased more cheaply from a commercial insurance company.

growing strength of union clinics and hospitals may also be a factor, although probably not a serious one. A severe depression, or even a moderate recession might well have an adverse effect.

Types of Plans. There are three types of plans. Some, but not many, are wholly local. Membership in these plans is confined to residents of one locality, which may be a city, town, or county. More than one hospital may be participating, depending upon the size of the community. A second type is local but has state-wide membership. In these plans, "out-of-town" members are paid cash allowances for hospitalization in institutions not under contract with the local organization. The third type is state-wide, not only in membership, but in contracting hospitals as well, and the trend is strongly toward this type. A few plans serve small areas in adjacent states, areas which are usually portions of a metropolitan economy, and in North Carolina there were in 1953 two plans, each state-wide and in competition with one another. Local plans exist independently of the state or area plans in a few states.

Plans may also be classified in another way. Some Blue Cross plans are of the cash indemnity type. That is, they make specified cash payments upon hospitalization. Others provide specified kinds and quantities of service benefits. Still others have a combination of the two.

Benefits. The scope of service benefits offered by plans is rather broad, although complete coverage is not usually provided. There is considerable variation as between different plans, but there is a trend toward uniformity and complete coverage. Within any given plan, most members are entitled to the same benefits, except where different types of room accommodations are offered as options, with different rates. However, the plans will now write special contracts providing different combinations of benefits to meet the needs of particular groups, especially employees of large organizations.

Usually hospitalization is provided for all disabilities except venereal diseases, self-inflicted injuries, injuries sustained in riots, war, and violation of laws. Illnesses or injuries covered by workmen's compensation acts are excluded, since they are paid for under the provisions of those acts, at least in part. Nervous and mental cases, tuberculosis, and virulently contagious diseases not ordinarily accepted by hospitals are usually not included, but the trend is to

include them also for limited periods of hospitalization.¹⁵ Tax-supported facilities for the care of some of these types of cases are generally available, although not to be sure always without cost. Maternity cases are covered in full or in part after a waiting period of from eight to 12 months, but generally only for a limited period of time such as seven to 12 days. However, it is becoming fairly common to waive maternity restrictions for large groups where 75 percent or more enroll. It is not common to cover admissions to hospitals for diagnosis only.

Types of room accommodations offered vary. In most plans, only semiprivate room service is provided. In some, accommodations may be either ward or semiprivate. A negligible number offer only ward accommodations, mostly in those Southern states where no other kind is available in quantity, and the number offering private rooms is also small. The situation changes rapidly, but as of December 1, 1946, it was summed up as follows: Of "approximately 113 main or standard contracts issued by the 81 plans, 5 provide care in a private room, 48 provide care in semiprivate accommodations as these are defined by the plan or hospital or of the area, 30 provide care in ward accommodations, and 30 provide a dollar room allowance."¹⁶ A few plans offer both ward and semiprivate contracts, and even fewer offer a private room contract. Members electing more expensive accommodations than those offered by the service plan, whether because of preference or physicians' orders or unavailability of cheaper accommodations, pay the difference in cost out of their own pockets. There is a tendency, however, to limit this privilege, because many hospitals charge higher fees for other hospital services to single-room patients.

Many plans merely allow fixed cash payments to subscribers electing single-room accommodations, or allow amounts equal to what would have been paid to the hospital if the subscriber had taken ward or semiprivate accommodations. In these cases, the subscriber is entitled to all of the other hospital services provided by the plan. This is a relatively recent development, stimulated by the difficulty of defining precisely what constitutes a given type of room accommodation, by variations in rates charged for the same type by differ-

¹⁵ Louis H. Pink, "Contracts Can be Liberalized," *The Modern Hospital*, April 1947, pp. 75-76.

¹⁶ Louis S. Reed, *op cit*, p. 33.

ent hospitals, and because of the increasing difficulty of reaching agreements on amounts to be paid to hospitals.

In cases of emergency, which means being out of town or out of the plan's area and in need of hospitalization, cash allowances equal in amount to those that would have been paid to a home-town hospital may be paid. Somewhat less than 10 percent of hospitalizations are of this type. A reciprocity program developed, under which a member of one plan admitted to a hospital participating in another plan received the benefits provided by that plan, or in some cases his own, whichever was the more advantageous to him. Because low-benefit plans were at a disadvantage in this type of arrangement, the program was not generally satisfactory and as a substitute an Inter-Plan Service Benefit Bank operated by the Blue Cross Commission was established. For its members hospitalized by the "host" plans, each plan pays into the Bank an amount equal to its average *per diem* payments to its own participating hospitals, plus or minus a small adjustment charge to reduce the loss to the host or home plan. The hospitalized itinerant member receives the benefits of the "host" plan, which pays the charges and is reimbursed the amount charged the home plan.

The maximum number of days of hospitalization allowed for each individual member generally varies from 21 to 120. Some plans allow a greater number of days in the second and succeeding years of membership. There is a trend toward providing maximum amounts of hospitalization per illness, rather than per year, which means greater protection to members and also simplified administration. Interestingly enough, the plans now using this practice generally offer as many days per illness as other plans offer per year. Most plans provide discounts of from one-tenth to one-third on hospital bills for from 60 to 90 days after the insured maximum has been exceeded. Approximately 95 percent of hospitalizations under non-profit plans are for 21 days or less, and about 75 percent are for 10 days or less.

The services always include ward or semiprivate room, board, usually including special diets, and general nursing care. More than that is frequently included. The use of operating and delivery rooms, administration of anesthesia by a hospital anesthetist, drugs, dressings and laboratory services which are "routine," "ordinary," "customary," are usually included. About half of the plans provide some physiotherapy services. More than half of the plans, including nearly 80 percent of the members, provide radiological services for diag-

nostic purposes, although generally only in limited amounts. Ambulance service is not usually supplied.

A growing number of plans have provision for out-patient service, each visit being counted as one day of hospitalization, although in some plans the hospital is being paid the amount that a private physician would have charged for such treatment. And many plans provide visits to out-patient departments to receive emergency attention not requiring hospitalization. Plans generally include all or most of the services rendered to the public by member hospitals

Premiums. In the early days of the movement, some plans charged the same rate to each subscriber, whether single or married, with or without dependents, but the practice was discontinued long ago. It is now common to find what is called a two-rate structure, in which the single member without dependents pays less than the rate paid by a subscriber with dependents. This was by far the most common rate structure found as of 1954. Some plans distinguish between single individuals, charging females slightly more than males, because females make more use of hospital services. Some plans also distinguish between families with and without children, having a slightly lower rate for families without children than for families with children. A few plans have separate rates for nearly every conceivable situation—for example, for one person, male or female, widow or widower with child or children, husband and wife, and family. A few plans now also provide a separate rate for “sponsored dependents,” usually family members not eligible under the regular family rate, such as children above 18.

Premium rates vary considerably, depending on the type of room accommodations offered, services included, and localities. They are therefore difficult to compare. It must also be noted that standardized designations for different types of services, especially room accommodations, do not exist. Furthermore, changes are constantly being made somewhere. With these limitations in mind, the following summary will give a fair idea of charges, as of December 1, 1953, made to members enrolled as groups.

Rates for a single subscriber and semiprivate room ranged from \$1.00 to \$4.25. In nearly 70 percent of the plans, the rate was below \$2, and in the remainder it was at or above \$2. The most common rates were \$1.40 and \$1.50. The number below \$1.40 and above \$2.50 was negligible. In triple-rate semiprivate plans, the most common rate for two persons was about \$2.50, found in slightly more than 36 percent of the plans having three different rates. One-half

of these plans charged couples more than \$3.00, but only two plans charged more than \$5.00. The most common charge for families in triple-rate semiprivate plans was \$3.50, found in approximately 30 percent of the plans. There was no such thing, then, as a typical set of monthly rates for semiprivate-accommodations plans, but \$2 for a single subscriber, \$3.50 for a couple, and \$4.00 for a family would be as good a set as could be given.

Many plans have separate rates for different types of room accommodation, or different cash allowances for rooms. Rates for ward accommodations generally run from 50 to 80 cents less than for semiprivate rooms.¹⁷

The unweighted average of dues being charged by all plans for all types of contracts as of June 30, 1948, was \$1.01 for one person, \$1.93 for 2 persons, and \$2.36 for a family.

Contracts made with subscribers in the beginning of the movement were generally for a period of one year. That practice presented real administrative difficulties when it became necessary to raise rates, since new rates could be introduced only at the expiration of contracts. To avoid this difficulty, it has become common, although not universal, to make contracts subject to cancellation or revision on short notice, usually 30 days or less.

These premium rates are usually uniform for all subscribers in the plan, except that those paying premiums individually rather than through a group usually pay somewhat higher rates. However, the Chicago Blue Cross developed on an experimental basis a so-called "cost contract" which was made available to firms in Chicago. Under this plan, the firm deposits the estimated three-month cost of hospitalization for its employees. At the end of the period the actual hospital cost plus administrative expenses is computed and the necessary adjustment is made in the next three-month deposit. Thus "experience rating" of the retrospective type enters into the picture, since the amount of hospitalization required will vary with the occupational group and the particular employer concerned. Where this option is available, the good risks will tend to choose it, thus making it necessary to increase the rates on other risks.

Contributions, or premiums, are frequently collected from the group by the employer through pay-roll deductions. Experience has proven that those groups are the most desirable risks. The trend is for plans to demand pay-roll deduction of premiums whenever

¹⁷ See *Blue Cross Manual*, Blue Cross Commission, 1954, for rates by plans.

that is feasible. Attempts are being made to induce the Federal government to deduct nonprofit hospital care insurance premiums from Federal employees' salaries and in one health bill there was a provision that would have authorized such deductions. Some employers object to deducting the contributions, because when they are added to social security and withholding taxes and union dues, the total appears to many workers to be too large.

Some employers themselves pay a part or all of the cost, and this practice is becoming more prevalent. In 1947, about 8 percent of all membership fees were paid by employers.¹⁸ Many collective agreements between unions and employers provide that the employer will pay the entire premium.¹⁹ The Blue Cross Commission has established systematic relations with labor unions to encourage the inclusion of hospital benefits in collective agreements.²⁰

In cases where the employer does not himself bear the cost and where he does not deduct the premiums from the workers' wages, the group frequently designates someone to serve as an agent. The agent collects the premiums and remits them to the Plan. Many plans require quarterly or semiannual payments in advance, although it is now common for payments to be made monthly. If collections exceed hospital and administrative expenses, the surplus is accumulated as a reserve, and this surplus is used only to increase benefits or to decrease premiums. The trend has been to use surplus to increase benefits.

Enrollment. Membership in hospital service plans is usually acquired through a group, generally an already existing group such as the employees of a business concern, members of a trade union, or farm or professional organization. Sometimes an entire community is the group. Not all members of any given group need to participate. Indeed, there are some specified limitations such as age and in some plans minimum or maximum income or both.

In the early days of the movement, only a small percentage of any group was required in order to secure membership, but now that the movement is fairly well established a high percentage is fre-

¹⁸ Richard M. Jones, Blue Cross commissioner, in *The Modern Hospital*, August 1947, p. 130.

¹⁹ Princeton University Industrial Relations Section, *Group Health Insurance and Sickness Benefit Plans in Collective Bargaining*, 1945. See also Evan Keith Rowe and Abraham Weiss, "Benefit Plans under Collective Bargaining," *Monthly Labor Review*, September 1948, pp. 229-234.

²⁰ Blue Cross Commission, *Annual Report of the Director, 1945-1946*, p. 19.

quently required. It is common now to require that from 50 to 75 percent of any group as small as 25 must join, and from 40 to 50 percent for larger groups. One state-wide plan, for example, has the following provision: for a group of from 5 to 8 persons, there must be at least 5 applications; for a group of from 9 to 12, there must be 100 percent minus 3; for a group of from 13 to 20, at least 10 applications; and for groups of 21 or more, 50 percent. This practice, borrowed from commercial insurance, is supposed to reduce the element of adverse selection, but there is some difference of opinion as to how effectively it does so. Enrollment is generally "reopened" from time to time to admit old members not previously enrolled and new members added.

Furthermore, admission of any group to membership now is generally scheduled. A new group wishing to join makes application and the time when it will be admitted is established by the directors of the plan. Here again it is considered possible to guard against adverse selection. A major exception to group enrollment was made by many plans in order to admit veterans on an individual basis. A national drive in 1946 resulted in the enrollment of an estimated 100,000 veterans in May and June. Attempts are also being made to enroll members as individuals in metropolitan areas and in rural communities.²¹ Experience with individual enrollment has been sufficiently satisfactory to justify its continuation.

New members of any existing group may be admitted either individually as they become members of the group, or at stated intervals thereafter, the application being held usually for say 30 days in order to avoid the expense of enrolling "floaters" and to avoid adverse selection. A member enrolled through a group and who later leaves that group may continue his membership, either by associating himself with another enrolled group or as an individual. It has been estimated that from a third to a half of those who enroll through a group and later leave that group continue their membership as individuals.

No health examinations are required for admission through groups, but it is not uncommon to require the individual subscriber to take a physical examination or sign an application card indicating that the applicant is "not suffering from any condition known to require hospitalization." In some plans, conditions known to require care at the time of enrollment are covered after say eight months of

²¹ Blue Cross Commission, *Annual Report of the Director, 1945-1946*, p. 20.

membership. When members are enrolled in groups and when the time of admission is scheduled, lack of health examinations does not introduce any serious or lasting element of adverse selection.

Plans do not generally have maximum age limits when enrollment is through groups, but accept anybody in the group. Approximately 30 percent of the plans do have maximum enrollment ages, mostly 65 years. Once obtained, membership is usually not lost on reaching some specified maximum age, except in a very few plans. Children enrolled as family dependents do, however, lose that status upon attaining 18 or 19. And quite frequently infants under 30 or 60 days of age are not covered.

Utilization. Participants in hospital care plans have not abused their rights to benefits.²² The hospital admission rate is slightly higher for Blue Cross members than for the general civilian population, but the average length of stay is appreciably less. The length of stay is shorter than for nonmembers largely because members receive more hospitalization for minor illnesses and because participants are mostly the actively employed and their dependents. If maternity cases are excluded, the total amount of hospitalization per person has not been much greater than for nonmembers. Maternity benefits are definitely an inducement to join for people who plan to have children, and for some years now the birth rate has been exceptionally high.

However, in recent years utilization has increased appreciably and there have been charges of unnecessary admissions, unnecessarily prolonged preoperative medication and treatment, overstay in certain types of cases, and excessive use of expensive drugs and of laboratory tests.²³ Responsibility for these abuses falls in part on patients who insist on unnecessary hospitalization and expensive drugs, and partly on physicians who find it more convenient to treat patients in hospitals. But part of it rests on the Blue Cross movement itself because the advertising it uses to compete with commercial agencies leads the subscriber to expect more than he should have.

The relative extent of utilization by different types of members has been well established. The following conclusions by an outstanding student of the movement are based on 10 years of experience and approximately 25 million member years of exposure:

²² Blue Cross Commission, *Annual Report of the Director, 1945-1946*, p. 2.

²³ Kenneth B. Babcock, "The Excessive Use of Blue Cross Benefits," *Hospitals*, July, 1952, pp. 49-51.

"Other things being equal, women require about 50 percent more hospitalization than men. Most of the difference is to be explained by the hospitalization for conditions peculiar to women. The ratio applies to all classifications of subscribers. Women dependents use considerably less care than employed women. Women with children use less care than women without them. Married men use less care than single men. Children receive less hospitalization than adults."²⁴

Hospital Payments. Voluntary nonprofit hospital care plans are not of the indemnity type, which pay cash to the insured person, but they guarantee specified amounts of service. The plans make contracts with participating hospitals that are willing to provide the services guaranteed by the plan, and the contracts include the basis upon which charges are to be computed. The hospitals then bill the service plan directly for the amounts due them for services rendered according to the agreement, and they bill the patient only for those charges, if there are any, which are not payable by the plan. Usually Blue Cross patients are not required to make an advance deposit when they are admitted to the hospital. Approximately two-thirds of the general and short-term hospitals, with more than 90 percent of all beds in nongovernmental hospitals, have entered into agreements to provide services.

The problem of devising a satisfactory formula for determining the amount to be paid hospitals for services rendered has not been an easy one to solve to the satisfaction of all concerned. In the early days of the nonprofit movement, when hospital admissions were far below bed capacity, there was no serious problem in reaching agreement, for hospitals were eager to participate in any plan that promised them additional revenue. Usually flat-rate payments for room accommodation and designated services were established in each community, based more on the plan's ability to pay than on the cost of providing the services. But as Blue Cross membership grew and the depression of the 1930's passed, and especially during the prosperous years following the Second World War, utilization of hospital facilities and ability to pay both increased. Much controversy developed over what should be the proper method for determining hospital charges. Different methods are in use.²⁵

²⁴ C. Rufus Rorem, *Community Hospital and Medical Plans*, American Hospital Association, 1944, pp. 10-11.

²⁵ See E. A. Van Steenwyk, "Blue Cross Payments Pose a Problem in Cooperation," *The Modern Hospital*, July 1947, pp. 71-76, and also "There Are Ogres in the Hospital Basement," April 1947, pp. 48-51; C. Rufus Rorem, *Blue Cross Hospital Plans*; Louis S. Reed, *op. cit.*, chap. 5.

One method of determining how much a plan should pay is to "gear" the rates to the hospital's charges. This may be done by paying a straight *per diem* for room accommodations based on the hospital's average charges or collections. The rate may be weighted to differentiate between the relative importance of surgical, medical, and maternity cases, or weighted by length of stay. Because short-stay cases involve relatively higher *per diem* costs than do those requiring prolonged hospitalization, it has become fairly common practice for plans to pay larger amounts for such cases, as for example \$15 for the first day, \$25 for two days, \$30 for three days, and \$8 per day for stays of four or more days. Payments may also be geared to charges simply by paying the hospital on an "as billed" basis less a discount, but with a ceiling on the *per diem*. Or the payments may be the charges "as billed" with a ceiling on the *per diem*, but with no discount.

Another method is for hospitals to charge the prepaid care plans on the basis of cost, but not to exceed the amount charged to non-members. The definition of cost is quite liberal, including interest, depreciation, obsolescence, and the accumulation of a small reserve or surplus. The marked increase in the cost of operating modern hospitals has made it necessary to raise room rates and service charges to the plans as well as to the public, and that in turn has made it necessary for the plans to raise premium rates to their members. This method has become common in recent years, but there is much protest against it. Some plans have attempted to hold membership subscription rates down by limiting the type and amount of services offered and by requiring the member to pay a small portion of the special service charges.

The method of gearing payments to hospital charges, but paying somewhat less than regular charges, has been preferred by prepaid hospital care plans because it offered lower rates and more certainty in the matter of total payments. Those who favor this method have argued that the plans have made for fuller utilization of hospital facilities, that there are no collection losses on prepaid patients, and that the added business can be handled by hospitals at a relatively lower per unit cost. They point out that despite increasing costs, hospitals are in better financial condition today than ever before, and that fuller utilization and better collections achieved as a result of the plans are the major reasons for that better condition.²⁶ Pay-

²⁶ Current data on percent of occupancy, receipts per bed, and average cost per bed will be found in current issues of *Hospital Management*

ment on a regular charge basis ignores the absence of collection charges, and furthermore, regular charges may in many cases not be related to either costs or quality of service, and they involve the problem of checking hospital bills against regular charges made to the public. And finally, when regular charges are made, rates may be changed at will by unilateral action. If prepaid plans are to continue to expand, low rates must be maintained and this requires relatively low charges. Payment on a cost basis is said to penalize good management and reward poor management. It is difficult also in many cases to determine costs, especially to allocate them to any one type of accommodation when several types are available. This allocation could be made by cost accountants if adequate records were available, but they are not generally available.

Hospitals, in general, want as much from prepaid plan members as they get from nonmembers. They want payments to be on an "as billed" and without ceiling basis. The trend is definitely in this direction. The Blue Cross Council on Administrative Practice recommended that hospitals be paid on a cost basis but not to exceed charges made to the general public for similar services.²⁷ This would appear to mean in effect an "as billed and no ceiling" basis. Indeed, the Council's definition of reimbursable costs is so broad, including interest, depreciation, and surplus for expansion, that the billings could be for more than actual cost.²⁸

The cost of training the medical profession is recognized by all concerned as one that should be borne by government and philanthropy and one that should not be passed on in the form of hospital charges. It is also recognized that the cost of modernizing our existing hospital facilities and adding sorely needed new ones cannot be charged to the patients using those facilities. The role of government in expanding hospital and medical center facilities is now predominant.

Hospital administrators appear, many of them, to be convinced that prepaid care plans are fully able to pay at least standard rates. They point to the reserves accumulated by many of these plans, and some argue that the reserves are too high. Some go so far as to argue that hospital guaranteed service contracts are no longer

²⁷ Blue Cross Commission, *Annual Report of the Director, 1945-1946*, p. 18.

²⁸ E. A. Van Steenwyk, in *The Modern Hospital*, July 1947, p. 75. One plan was reported as paying \$10.75 per day to a hospital having a *per diem* cost of \$9.90 and which collected from other paying patients \$8.70 per day. *Hospital Management*, October 1947, p. 28.

necessary, that the plans can afford to go on a cash indemnity basis, and that hospitals come out better with private indemnity insurance contracts. Some point out that commercial insurance carriers have adopted the benefit standards of prepaid plans, and that the movement itself is really no longer needed. All of this seems to ignore, or to write off, the most fundamental characteristic of the movement, namely the hospital guarantee of the services promised to members, without which the plans would probably no longer be eligible to tax exemption, and without which the plans would probably lose much of their popular appeal and public good will. A few hospitals have withdrawn from the movement, but the number is very small.

The controversy over how much nonprofit hospital care plans should pay to hospitals for the services rendered their members is not likely to abate much in the near future. Competition from commercial insurance companies selling cash indemnity hospital care policies will continue to exert considerable pressure on the nonprofit plans. Administrators of nonprofit plans are likely to continue to press for some kind of differential treatment in order to be better able to meet that competition. They are also under constant pressure to expand the benefit coverage of their plans, and they are eager to enlarge the size of their membership. High costs necessitate high membership subscription rates, which in turn mitigate against expansion. Restricting benefits and requiring members to pay even a small part of special service charges, such as for x-rays and laboratory tests, will not appeal to many of them as desirable. It does not seem likely, however, that the governing authorities of hospitals, confronted with ever-mounting costs and with protests from the public over their high charges, will be able to favor the nonprofit plans, not to an appreciable extent at any rate. Even municipally owned or subsidized hospitals find it difficult to get along on their budgets, and the idea of raising taxes to meet hospital deficits does not appeal to local officials. It is well to remember that hospital governing authorities have always dominated the Blue Cross movement. Without their cooperation, the movement could not guarantee benefits in terms of service.

There is some danger to the prepaid hospital care movement in all of this. One administrator in the movement has said that it will "continue to be in danger as long as the vain hope persists that some kind of magic" exists in those plans that makes them able to pay

higher rates.²⁹ It may not be "magic" that hospital administrators see, but simply the law of supply and demand, working for once on their side. The administrator continues:

There is no hope for the voluntary hospital system unless the leadership of our hospitals stops its present double-talk. The double-talk which says to the listener that hospitals understand how a sound Blue Cross plan should operate yet insist upon individual treatment without any limit for each hospital that wants something different is today's great peril. Unless it is corrected this kind of double-talk will result in the abandonment of nonprofit hospital insurance.³⁰

The most fundamental feature of hospital care plans has been that the benefits promised to subscribers are guaranteed by participating hospitals. However, not all hospitals participating now underwrite the plans, and many more do not fully underwrite them. A relatively small number of hospitals refuse altogether to guarantee the services or to accept reduced payments should the plan experience financial difficulties. But a substantial number reserve the right to cancel contracts on notice so short that a plan in real difficulty would not have adequate time to readjust its rates and continue in operation. On the basis of a survey of 36 plans, one authority writes as follows: ³¹

Assuming that the surveyed plans can be accepted as representative of all the plans, it would appear that slightly more than two-thirds of all the plans are contractually underwritten by their member hospitals, while a little less than one-third of the plans are not so underwritten. However, it should be added that it is the writer's impression that in the case of most of the plans in which hospitals do not guarantee subscriber benefits the hospitals would come to the rescue of the plan if it got into financial difficulties. (This backing, however, might depend on whether the hospitals thought the plans well managed and upon the extent of aid required.) In other words, the hospitals of these plans feel a certain moral obligation toward the plan which would in all probability lead them to back up the plan. The self-interest of the hospitals would also impel in the same direction since hospitals could hardly afford to permit the collapse of a plan which had become valuable to them.

²⁹ E. A. Van Steenwyk, in *The Modern Hospital*, July 1947, p. 76 and Abraham Oseroff, February, 1954, p. 65. Mr. Oseroff finds the greatest danger to be in the trend towards a local basis for the solution of problems. He urges the extension of nation-wide programs established by union-management collective agreements.

³⁰ *Ibid.*, July 1947, p. 76.

³¹ Louis S. Reed, *Blue Cross and Medical Service Plans*, p. 57.

There are two substitutes for hospital underwriting. One is the accumulation of adequate reserves by plans. A reserve sufficiently large to see a plan through six months or a year would generally enable that plan to readjust its affairs. The second substitute is a reinsurance fund to which all plans would contribute and from which funds could be made available to plans having financial difficulty. A combination of hospital underwriting and reinsurance would materially reduce the need for reserves by individual plans.

Organization. The plans are as a rule organized as nonprofit corporations, in most states under special enabling legislation which classes them as nonprofit charitable and benevolent societies exempt from the insurance code but subject to some degree of supervision by the insurance department. The corporations are generally exempt from state and local taxes, except on real estate in some cases, but are subject by the Federal government to social security taxes. About one-third of the special enabling acts require that participating hospitals guarantee subscriber benefits, and nearly all of the laws limit dealings to hospitals operating under the laws of the state. The plans in Indiana, Oklahoma, and Sacramento, California, are organized as mutual insurance companies. The Sacramento plan has been dropped from the Blue Cross system.

Each corporation has its trustees or board, representative of participating hospitals, doctors, employers, and the public, all serving without compensation. Governing boards are normally either designated by hospitals and the medical profession altogether, or those so designated elect public representatives, or they are "self-perpetuating," i.e., designate all members. In a very few plans, subscribers elect the board. Where subscribers are consulted, nominees presented by the boards are generally elected, and the boards are thus practically self-perpetuating. No practical method has been devised for enabling millions of subscribers enrolled through thousands of groups to elect boards of directors. Some plans use an appointed advisory committee of subscribers. The plans are thus "producer" rather than "consumer" controlled organizations, although there is no evidence that as producer organizations they attempt to take undue advantage of the consumers. Yet in any conflict between hospitals and plans, and there have been numerous such conflicts, the hospital administrators would seem to have the advantage. The problem of control has yet to be solved.

There are paid employees to administer the plans, and not infre-

quently there are salaried "field" workers to solicit group membership, or to "educate" the public. In the early days of the movement, solicitors played an important role in "selling" the idea, but in recent years their importance has declined somewhat, although they are still the spearhead of the movement. The cost of administration, including promotion, has recently amounted to about 13 percent of income, although in the more efficient plans it has been appreciably lower. Administrative costs are increasing.

The corporation through its officers makes contracts with approved hospitals which are willing to participate. Hospitals normally guarantee for the duration of the contract to provide the services to which the insured are entitled under the plan, irrespective of the financial status of the corporation. This feature distinguishes the nonprofit hospital plans from most other "mutual" nonprofit insurance plans.

Government supervision of the corporations is generally exercised through state insurance or public welfare departments, although the insurance code is not applied to them. Where hospitals underwrite the plan, small reserves are adequate. The Blue Cross Commission has said that reserves equal to five months income or seven months hospitalization are adequate, but suggests that eight months hospitalization would be better. Insurance commissioners recommend five times annual income or seven times annual payments.³⁶ Most plan officials are glad to have state insurance department supervision. In a few states, the corporations are subject only to the same regulation as other corporations, on the assumption that they are engaged in selling services and not insurance. Generally they are considered as charitable and benevolent institutions and not subject to taxes.

Nonprofit hospital care plans are in an increasing number of instances being connected with medical care plans sponsored by local or state medical societies. The connection assumes different forms. In some plans, 10 in 1946, the combined protection is offered through the same corporation, which thus administers both the hospital and medical care plans. In others, 29 in 1946, each plan is offered by its own corporation, but the hospital plan staff is utilized by the medical care plan to carry out enrollment, collection, and

³⁶ Blue Cross Commission, *Annual Report of the Director, 1945-1946*, p. 22; *Hospital Management*, October 1947, p. 29.

other administrative details. Policy matters in the medical care plans are determined by the medical societies.³⁷

Some Financial Data. Nonprofit prepaid hospital care insurance has become a substantial business operation. Some financial data for the Blue Cross are presented here to give the reader a glimpse into that business.³⁸ Table 67 shows total assets and their distribution according to size of plan at the end of 1953.

TABLE 67. Assets of 85 Blue Cross Plans, December 31, 1953,
by Size of Plan ³⁹

Number	Size Class	Percent of Membership	Assets	
			Dollars	Percent
11	1,000,000 or more	51.6	\$203,345,789	55.1
15	500,000 - 1,000,000	22.3	87,934,143	23.8
29	200,000 - 500,000	20.7	62,134,742	16.8
12	100,000 - 200,000	3.5	10,840,403	2.9
8	50,000 - 100,000	1.3	3,316,862	0.9
10	Less than 50,000	0.6	1,819,340	0.5

Assets of 85 plans as of December 31, 1953, totaled \$369,391,279, of this, \$270,824,081 was invested, \$76,735,310 was in cash, \$20,991,471 consisted of accounts and notes receivable, and \$840,417 was in other assets. The total was 21.2 percent more than in the previous year.

Total reserves at the end of 1953 amounted to \$194,675,669, an average of \$4.22 per participant, as compared with \$3.50 at the end of the previous year. Total 1953 reserves had a purchasing power of 3.17 months of hospital care, whereas the 1952 reserves had a purchasing power of only 2.19 months of hospital care.

Operating data for the year 1953 throw some light on the flow of money into and out of Blue Cross coffers. The summary figures given in Table 68 show this flow by size of plan and by type of expenditure.

Taken as a whole, the movement prospered. Total income was

³⁷ Blue Cross Commission, *Annual Report of the Director, 1945-1946*, p. 23. The medical plans so affiliated are called Blue Shield plans.

³⁸ See Louis S. Reed, *op cit.*, chap. 10, for a more detailed exposition

³⁹ Data from the Blue Cross Commission of the American Hospital Association.

greater than total expenses, and net income varied from 5.8 percent of income for plans in the 100,000 to 200,000 class to 3.3 percent for plans with from 50,000 to 100,000 members.

Hospital expenditures accounted for 88.01 percent of all expenses, a decrease from the 88.56 for 1952, and operating expenditures accounted for 7.0 percent, as compared with 7.47 for 1952. A larger percentage of total expenditures went to hospitals, 89.04, in the plans having more than 1,000,000 members than in any other size class, the lowest being 85.01 for plans having from 100,000 to 200,000 members. The largest percentage of its revenue paid to hospitals was 99.07, by the plan headquartered in Newark, New Jersey, with

TABLE 68. Operating Statement for the Year Ending
December 31, 1953, for 85 Blue Cross Plans ⁴⁰
(Dollar Figures in Thousands)

Plans		Total Income	Expenses		Net Income	
Number	Size Class		Hospital	Operating	Dollars	Percent
11	1,000,000 or more	\$407,557	\$362,914	\$25,831	\$18,812	4.6
15	500,000-1,000,000	179,296	154,702	13,722	10,872	6.1
29	200,000- 500,000	139,907	123,184	10,226	6,497	4.6
12	100,000- 200,000	26,413	22,453	2,428	1,532	6.8
8	50,000- 100,000	8,186	6,975	940	271	3.3
10	Less than 50,000	4,244	3,610	432	201	4.7

1,936,000 members, and the lowest was 70.99 by the plan in Washington, D.C., with 549,607 members. There appears to be no correlation between size of plan and percentage of payments made to hospitals.

The ratio of operating expenses to income varied from a low of 6.34 for the more than 1,000,000 class to a high of 11.48 for plans having 50,000 to 10,000 members. There is a fair degree of correlation between size of plan and the ratio of income to operating expenses. The larger plans generally have the lowest ratios, and the smaller the plan the higher the ratio. However, it is not too uncommon to find exceptions to this rule.

The trend in expenditures over a period of eight years is shown in Table 69. Hospital rates have increased considerably in recent years, and it is that rather than increasing utilization which accounts for the marked increase in the proportion of total income going to hos-

⁴⁰ *Ibid.*

pitals. These increasing hospital costs rather than the moderate increase in operating costs account also for the marked decline in net income from 13.19 percent in 1942 to 3.24 percent in 1947. Higher rates to subscribers brought the net to 4.99 percent in 1953.

Thirteen plans had operating deficits in 1953. Altogether they lost \$3,097,210, which amounted to approximately 0.4 percent of total income for the year. The deficit did not exceed 10 percent of net in-

TABLE 69. Percentage Distribution of Total Income, Blue Cross Plans, 1944-1953

Year	Plans	Hospital Expense	Operating Expense	Net Income
1944	73	76.22	12.30	11.48
1945	86	81.37	12.29	6.34
1946	87	82.34	13.01	4.65
1947	90	85.62	11.14	3.24
1948	90	85.34	9.72	4.94
1949	90	84.46	8.82	6.72
1950	90	87.62	8.37	4.01
1951	88	89.21	8.11	2.68
1952	87	88.56	7.47	3.97
1953	85	88.01	7.00	4.99

come in any plan, was between 5 and 10 percent in two, and below 5 in ten. The greatest loss was 7.5 percent and the smallest was negligible. For 1947, the record was worse. A total of 30 plans lost an aggregate of \$3,071,560. That was an increase of 50 percent over the 1946 dollar losses, and it amounted to 1.45 percent of total income. The situation at the end of 1947 was certainly serious, although it was not alarming. But some of the plans appeared to be in a precarious condition at that time.

BLUE CROSS

Group hospital care plans which are supervised through an approval program established by the American Hospital Association and administered by the Association's Blue Cross Commission are known as Blue Cross Hospital Plans. Blue Cross plans do not differ fundamentally from other nonprofit hospital care plans, but because they include more than two-thirds of the total membership and because they have developed into a coordinated national system under

the guidance of the American Hospital Association, an outline of the controls will be given here.⁴¹ Approval standards have been established by the Commission.

General Principles. The following general principles of organization are applied by the Blue Cross Commission to plans seeking approval to be identified with the movement. Approval authorizes the plan to use the seal of the American Hospital Association superimposed upon a blue Greek cross and the words "Approved by the American Hospital Association."

1. A substantial number of representatives from contracting hospitals should be on the plan's governing board. There should also be representatives of the public, and it is desirable that members of the medical profession also be on the board. The Commission does not require or recommend that hospital representatives constitute a majority of the board.

2. All the hospitals in a plan's area which are qualified and equipped to provide the services offered participating members should be given the opportunity to make contracts with the plan to provide those services. It is to the interest of subscribers that as many eligible hospitals as possible participate. The Commission believes that the plan should have contracts with at least a majority of those hospitals. Furthermore, the plan should make equitable provision for benefits for its subscribers who are received in noncontracting hospitals.

3. In order to be approved, a plan's area and population should be sufficiently large so that the risks assumed will be spread adequately. In other words, it must be possible for the "law of large numbers" to operate. An adequate population is needed also for efficient and economical management of the benefits. And the area must be large and populous enough to support the hospitals needed to provide the benefits promised.

4. Finally, benefits should be provided in the form of service rather than cash allowances. The Commission does not require that service rather than cash indemnity be offered. But it is on record to the effect that service benefits should be stressed.

⁴¹ See C. Rufus Rorem, *Blue Cross Hospital Service Plans*, American Hospital Association, 1944; United States Senate, *National Health Program, Hearings Before the Senate Committee on Education and Labor on S. 1606*, 79th Congress, 2nd Sess., Part 2, pp 929-969, Louis S Reed, *Blue Cross and Medical Service Plans*, 1947, chap 13, *Blue Cross Approval Program of the American Hospital Association*, American Hospital Association, 1953.

Standards. In addition to these general principles, the Commission has listed certain standards which must be observed if a plan is to continue to have its approval, to the extent at least that it is not prohibited from doing so by law or government regulation.

1. At least one-third of the governing board must be representatives of hospitals with which the plan has contracts to serve its members. Furthermore, at least one-third of the board must represent the general public. The Commission has moved away from the position that a majority of the board should be hospital representatives. As was said just above, the Commission believes that the medical profession should also be represented on the board.

2. The plans must be nonprofit in character. Trustees and members of the governing board shall receive no pay for their services, and no part of the net earnings shall be used for the benefit of any individual. If working capital is borrowed, it must be repayable out of earned income only, over and above operating expenses, benefit payments, and legal reserves. Furthermore, no one advancing capital shall be permitted to control or influence the operation of the plan because of the capital that has been advanced.

3. A plan must cover, in its most comprehensive option, an average of at least 75 percent of the charges for usual and customary hospital services to in-patients during the full coverage period. Usual and customary services are based on local practice in each case, but must include all items billed except physician's fees, private-duty nursing charges, and charges for convenience items not directly related to hospital care.

4. The plan must have written contracts with at least a majority of the eligible hospitals in its area containing a majority of the bed capacity. The contracts must obligate the hospitals to furnish the prescribed benefits to members, and they must be terminable on not less than 90 days' notice by either party. The plan assumes liability for the care rendered its members to the extent of the amounts promised, and for those amounts the patient is not liable.

5. Reserves adequate to protect subscribers to the plan and contracting hospitals must be maintained. The reserve must be adequate to meet liability for reported and unreported hospital admissions and in addition it must be adequate to meet all hospital and operating expenses for a minimum period of three months. If a plan's reserves do not come up to this specification, and if during the preceding twelve-month period the plan has been unable to add at

least 5 percent of its gross income, exclusive of liability for reported and unreported admissions, it must produce evidence which will convince the Blue Cross Commission and the American Hospital Association's Board of Trustees that its financial policies are sound.

6. Accounting and statistical records as prescribed by the Commission must be maintained, and each plan must submit to the Commission such reports as may be required.

7. In increasing enrollment, the plan is prohibited from using an independent sales agency. Furthermore, no employee of a plan who is used for promotion shall be paid principally by commission or on a production fee basis.

8. Provision is made for requiring participation in national programs sponsored or operated by the Commission, such as membership transfer and uniform enrollment and billing of national firms. A plan must participate in any such program when at least three-fourths of all plans, representing at least three-fourths of total membership, are participating. If participation in such a program will have serious adverse effects on a plan, the Commission may excuse it from participating. The degree of participation required is determined separately for Canadian plans.

The Blue Cross Commission. The Blue Cross Commission is composed of 15 persons, three selected by the American Hospital Association and 12 elected by votes of the member plans, which are divided into 12 districts. Each Blue Cross plan contributes 2½ mills per contract per month, with a minimum of \$40 and a maximum of \$1200 per month.

The Commission collects and distributes statistical data on finances and services, and gives administrative and other counsel to member plans. It has established arrangements for handling transfers of membership between plans and for paying out-of-town benefits. Applicants for transfer to a plan are accepted subject to verification of their membership in another plan by using a simple Transfer-In Acceptance Memorandum devised by the Commission. A job analysis and salary schedule for member plans has been developed which has improved operations in many plans.

A National Health Service, Incorporated, has been established, whose function is to contact firms having workers in two or more plan areas and to secure membership through one enrollment. Local plans may underwrite any portion of a national contract for members covered by it who are within their enrollment areas.

THE PRESIDENT'S RECOMMENDATION

Interest in prepaid hospital care plans was at one time so great that a determined move was made to incorporate the feature in Federal legislation. President Roosevelt in his Budget message to the Congress on January 5, 1942, recommended that hospitalization payments be made under the Federal Old-Age and Survivors Insurance system. One object was to increase the scope of the Social Security system, and another was to restrict inflationary purchasing power, to reduce what was then called the "inflationary gap."

Members of the Social Security Board's staff met with a Special Committee of the Board of Trustees of the American Hospital Association, and the Joint Advisory Committee of the American Protestant and Catholic Hospital Associations early in September, 1942, to discuss various technical aspects of the recommendation. It was agreed that participation in the conference did not imply acceptance or rejection by the participating associations of the President's basic policies in the matter. The conference was merely to assist the Social Security Board in its further deliberations on the problems involved.⁴²

Under such a plan as the one proposed, insured coverage would be more than 80 million, if dependents were included, and would increase, especially so if coverage should be extended to employments not now included in the old-age system. It was estimated that the cost would be somewhere between 0.7 and 1.5 percent of pay roll, depending upon the cost of hospitalization and certain other factors.

Two basic payment patterns were discussed. Under one, cash payment would be made to the hospitalized individual, or upon his assignment directly to the hospital. This was a "cash indemnity" plan. Under the other, prescribed amounts of service would be guaranteed and the hospitals would be paid by the insurance system. Neither pattern was considered to be entirely satisfactory by the representatives.

Hospital representatives seemed to prefer that the Government deal directly with the individual rather than with the hospitals, and

⁴² A summary of the discussions will be found in *Hearings before the Senate Committee on Education and Labor on S. 1606*, 79th Cong., 2nd Sess., Part 3, pp. 1716-1724.

that the benefit should automatically be assigned to the hospital, with the beneficiary having no discretion in the matter. But they appreciated the importance of making it clear to the worker that the Federal system paid the hospital bill. No doubt the fear of Government domination of hospitals accounted for this most peculiar suggestion. An outright cash indemnity plan would be more logical, although that would not guarantee payment to hospitals, and it would not necessarily guarantee the full amount of the hospital bill.

Most hospital representatives believed that payment should be related to the cost of providing basic hospital services in the individual hospitals and not on the basis of average costs. The rate would not necessarily exactly equal costs for any individual patient, but would be reasonably related. And most of them believed that no great difficulty would be encountered in arriving at a satisfactory figure for individual hospitals, and without the necessity for a detailed investigation of the costs of operation. It was agreed that the method of certifying benefits should be as simple as possible, but that it should insure that the hospital receive the benefit amount. There was also substantial agreement that an advisory council should be constituted to assist in carrying out such a plan, should one be adopted.

There was unanimous agreement that the growth and development of Blue Cross plans on a voluntary basis should be encouraged, and that the Government plan should be designed toward that end. But there was some difference of opinion as to whether that was possible, especially if the variable-payment plan should be used. One representative argued that if the Federal plan provided only minimum basic services, then Blue Cross could supplement the Federal system by providing services over and above the minimum, such for example as semiprivate or private rooms, radiological and pathological services, and other specialized benefits.

The President's recommendation was not adopted by the Congress.

COMMERCIAL HOSPITAL INSURANCE

Private insurance companies have for many years provided hospital benefits in connection with individual health-and-accident policies, and more recently as separate policies. There has been a marked expansion in the volume of these policies in recent years, and the number of persons eligible for substantial hospitalization

benefits under them is estimated to exceed three million, and millions of others are entitled to small payments in connection with individual health-and-accident policies.

The hospitalization policies provide specified cash indemnity payments, and they follow no standard pattern in their provisions. Each company offers numerous options to suit the needs of its customers. It may be said that roughly policies can be bought which pay from \$3 to \$8 daily room benefits for from 30 to 90 days, plus additional allowances for specified services such as operating room, dressings, laboratory, etc., in maximum amounts of \$100 to \$300. The premiums would be from \$25 up per year. Some widely advertised low-cost plans have so many exceptions and limitations that they provide but little protection. It is well to bear in mind the basic fact that comprehensive hospital protection cannot be bought for a mere pittance.

Commercial group hospital policies, mostly sold by life insurance companies in conjunction with other types of insurance, have attained substantial coverage and are becoming increasingly important. By the end of 1945, there were over 31,000 master policies covering approximately 9,550,000 persons, of whom about 56 per cent were employees and the remainder dependents. Premiums amounted to about \$55.5 million.⁴³ Employees covered by such policies in 1935 were estimated at about 38,000, and dependents covered in 1941 at least 1,250,000.

These are cash indemnity policies. Hospitals do not guarantee specified benefits and there are no contracts between hospitals and carriers. Although the type of policy issued is very much the same in all companies, the specific provisions vary considerably as between companies, and different policies will be sold by the same company. To a substantial extent, policies will be adapted to the needs and desires of the particular group involved. This flexibility of coverage provisions, and the cash indemnity feature which eliminates friction between the insurer and hospital and meets in part the needs of large employers with employees in different parts of the country, are making commercial group policies real competitors of Blue Cross plans.

Daily dollar room benefits are provided which will be paid in case of hospitalization. In some policies, the actual cost of a specified kind of room accommodation will be paid, but not to exceed a maxi-

⁴³ See Louis S. Reed, *Blue Cross and Medical Service Plans*, pp. 304-315; H. Ladd Plumley, *Budgeting the Costs of Illness*, National Industrial Conference Board, 1947, pp. 41-44.

mum dollar amount per day. Policies usually allow 31 or 70 days per disability. In addition to the room benefit, actual expenses for specified services, such as operating and delivery room, x-ray, drugs, anesthesia, are allowed, subject to a maximum dollar amount such as 5 or 10 times the daily room benefit. Maternity benefits may or may not be included, and there may or may not be a waiting period. Usually all disabilities except those covered by workmen's compensation laws are included. Dependents are usually included, if 75 percent of the employees having them enroll, but they usually are allowed lower benefits, and age limits of 3 months and 18 years are applied.

Premium rates obviously vary with benefits provided, as well as between companies. Low premiums will buy only a small amount of protection, since there is no magic in insurance of any kind. The following are examples. The monthly rate per \$1 daily room benefit for a 31-day hospitalization period is 11 cents, and 12.2 cents if the period is 70 days, including immediate maternity benefits for female employees in groups where less than 11 percent are women and where there are no special health hazards. Where more than 90 percent of the employees are women, the rates are approximately double. Higher rates are applied if there are special health hazards.

This is a single-rate structure. As with Blue Cross, there are double- and triple-rate policies where wives and dependents are included. Provision is made for adjusting premiums on the basis of experience, through rate changes or through dividends or retrospective experience rating.

CHAPTER TWENTY-ONE

PREPAID MEDICAL CARE PLANS

MEDICAL prepayment plans are designed to spread the cost of medical care by pooling risks and costs, to reduce medical overhead costs, or to stabilize the income of practitioners. A further objective in many recent medical society plans is to forestall compulsory health insurance.

In this country the first voluntary medical prepayment plans developed in the mining and lumbering regions of Washington and Oregon, where settlements were small and usually far removed from large urban centers.¹ Employees contracted with doctors and hospitals to care for workers injured in the course of their employment, sharing the cost with the workers. Later those states required by law that employers and employees contribute to the cost of medical care for industrial accidents covered by their workmen's compensation acts. Contracts were made by employers with hospital associations, commercial clinics, and later with medical society service bureaus, to care for the industrially injured. Many employers and employee groups then increased their contributions in order to provide themselves and their dependents with medical care for nonindustrial illness and injury as well. The movement spread slowly to other areas. Group medical care plans developed rather extensively in the railroad industry. In recent years there has been a remarkable expansion in number and types of plans and persons served.

GENERAL CHARACTERISTICS

As with all voluntary movements, there is more diversity than uniformity to be found in the many plans. Yet it is possible to dis-

¹ But see H. Ladd Plumley, *Budgeting the Costs of Illness*, National Industrial Conference Board, 1947, chap. vi, where the origin is said to have been in Tampa, Florida, a half century ago.

tinguish between different types of plans and to describe the principal general characteristics of the movement as a whole. The status of prepayment plans in 1945 is presented as a background to the development of medical society and Blue Shield plans, which now dominate the nonprofit movement.

Types of Plans and Members. There are five different types of organizations administering prepayment medical care. Fundamentally they all have the same general objective of making it easier to pay medical bills. But there are basic differences in the various types.

Industrial plans, which in 1945 accounted for half of the total reported on, include those sponsored by employers or employees of a business or establishment and covering only the employees of that business or establishment. These, it should be noted, are plans that provide for illness and injury not covered by workmen's compensation laws, although in many of them the same facilities are used for all injuries and accidents. Employers pay the medical cost in 16 percent of the industrial plans reported on, employees pay the medical cost in 42 percent, and the cost is shared by both in the remaining 42 percent. Many plans which include employees of a business or establishment are not called industrial, because they are not sponsored by the employer or employees of the business or establishment. Furthermore, the industrial plans sponsored by the employees alone could properly be included under consumer-sponsored plans. The number of industrial plans has become pretty well stabilized. In 1945, a total of slightly less than 1.5 million persons were eligible for medical care under industrial plans, and of these about 375,000, or 30 percent, were dependents of subscribers. Not all plans include dependents.

Medical Society plans are those sponsored by groups of doctors organized in medical societies and are usually on a county or state basis. They began in Washington and Oregon in the second decade of this century as a result of state laws requiring employers and employees to contribute to the cost of caring for industrial accidents. They represented what was called contract medicine and the medical profession did not generally favor their spread.

Recently, however, the American Medical Association has encouraged prepayment plans. The number of such plans more than doubled between 1943 and 1945, the number reported in 1945 being

TABLE 70. Number of Persons Eligible for Care Under Prepayment Medical Care Organizations, by Type of Organization, 1945²

Type of Organization	Number of Organizations	Persons Eligible for Medical Care		
		Total	Subscribers	Dependents
Total	229	4,599,212	2,388,150	2,211,062
Industrial:				
Financed by employer	19	212,590	90,180	122,410
Financed jointly by employer and employee	47	519,072	340,383	178,689
Financed by employee	49	522,854	450,526	72,328
Medical society:				
Washington and Oregon	22	954,100	354,100	600,000
Other states	31	1,640,256	722,245	918,011
Private group clinic	21	287,825	181,270	106,555
Consumer-sponsored:				
Financed partly by Department of Agriculture	5	23,553	5,552	18,001
Other	27	326,060	200,135	125,925
Governmental.				
War Food Administration and cooperating agencies	6	97,300	32,433	64,867
Other	2	15,602	11,326	4,276

53. In some states, enabling legislation appears to be so worded that medical society plans are given some measure of monopoly control.³ Nearly 2.6 million persons were eligible for medical care under these plans in 1945, which represents 52 percent of the total membership

² Margaret C. Klem, *Prepayment Medical Care Organizations*, Bureau of Research and Statistics Memorandum No. 55, Third Edition, Social Security Board, 1945, p. 16. The totals given here do not include 376,638 persons eligible on a reduced-fee basis. For descriptions of some individual plans, see Franz Goldman, *Voluntary Medical Care Insurance in the United States*, Columbia University Press, 1948, chaps. 6-8.

³ See Alford A. Linford, *Hearings Before the Senate Committee on Education and Labor on S 1606*, 79th Cong., 2nd Sess., Part 5, pp. 2582-2588.

of the 229 plans reported above. Membership in this type of plan is increasing rapidly and promises to increase for some time. The major factor accounting for this rapid increase in number of plans and enrollment was the movement to enact a national compulsory health insurance system, a movement which the organized medical profession has resisted with every means at its command. Membership for the most part consists of employees in business establishments. A more detailed analysis of the plans is made below.

Private group clinics constitute a third type. Many physicians, realizing the advantages to be gained by combining their skills, have associated themselves together and practice as a private clinical group, generally using joint office facilities and equipment. In the beginning of this movement, a fee-for-service principle of payment was used, each patient paying for whatever service he received. In the course of time, the prepayment principle was adopted by some, and later its use spread. Many of these clinics contracted to care for groups. The movement had a fairly substantial development, but one which was interrupted by the recent development of medical society plans described above. In 1945, there were 21 group clinic plans among the 229 reported above and some 300,000 persons were eligible for medical care in them, which amounts to about 8 percent of the number included in the 229 plans. It is not probable that this type will continue to grow in importance, but in many cases the arrangements have proved to be satisfactory to all concerned and will therefore no doubt be continued.

A fourth type is the consumer-sponsored plan. Groups of individuals have in numerous instances organized themselves for the purpose of providing medical care on a prepayment basis. The grouping may consist of the members of a union, residents of a housing project, farmers in a county, or residents of a county, or any other logical group. The essential characteristic of this type of plan is that it is organized and directed by the consumers themselves. The organization either hires physicians on a salary basis, or contracts with them to provide the necessary services. A staff is also hired to handle the routine business affairs of the group.

Such organizations are not numerous, and they are almost without exception small. There is no reason to believe that they will increase in importance. Membership in 1945 amounted to only 7 percent of the total for the 229 plans, although the number of plans amounted to 14 percent of the total. Groups organized, operated, and financed

by the employees of a business, which in this classification are included among the industrials, are truly consumer-sponsored and could logically be included under this title.

The fifth type of plan is the governmental. So far as numbers are concerned, this is the least important of all the types, accounting for only 8 of the 229 plans and having only slightly more than 100,000 members. Nearly all of these were plans sponsored by the War Food Administration for seasonal farm workers recruited, transported, housed, or placed by the War Food Administration or a cooperating agency, and were largely financed by the Federal government. Membership in the War Food Administration sponsored plans fluctuated considerably with the seasons, varying from 8 or 10 thousand to 40 or 50 thousand. At one time there were plans for employees of several of the National Parks, but they were discontinued during the war because the parks were closed to civilians. This type of plan was never of much importance.

An important development of the past few years consists of the medical care plans organized and operated by Blue Cross hospital care plans. They will be included with the medical society plans to be analyzed below.

Total membership in the plans tabulated above was just under 4.6 million early in 1945. It was estimated that approximately 6 million persons, or less than 5 percent of the noninstitutional population of the United States, participated in some form of medical prepayment plan, including dependents who were merely entitled to reduced fees for service. But this total does not include those participating in college student medical service plans, members of the armed forces, veterans, those eligible for medical care under workmen's compensation laws, or under commercial insurance plans, or recipients of public assistance in Kansas who are covered by a prepayment plan. These would add many more millions to the total, but how many is not known. The 6 million total does not include those who receive only cash disability benefits, nor those participating in hospital prepayment plans.

Almost the entire growth in membership between 1943 and 1945 was in Medical Society plans, and that is true of subsequent growth as well. Such plans in Washington extended services to dependents, and the medical profession generally became aggressive in seeking members. Consumer-sponsored plans not financed by the government more than doubled their membership, while membership in

governmental plans of all kinds shrank. Membership in industrial plans remained practically the same, but declined slightly in plans financed jointly by employers and employees.

Dependents accounted for 48 percent of the total persons eligible for medical care. Seventy percent of the dependents were in medical society plans, and 17 percent in industrial plans. Nearly all of the remainder were in private group clinics and consumer-sponsored plans. It is worth noting that industrial plans financed entirely by the employees have the lowest ratio of dependents to subscribers.

Membership Restrictions. Voluntary prepayment medical care plans have frequently found it necessary to establish standards of admission in order to avoid or to minimize the influence of adverse selection. There are many different kinds of restrictions, but the three major types are the entrance physical examination, age limits, and income limits. About 25 percent of the plans, mostly industrial, consumer-sponsored, and governmental, have none of these three restrictions.

Of the plans which have membership restrictions, nearly two-thirds have only one of the three types. The most common is the entrance physical examination, which is found in approximately 45 percent of the plans. However, in many of industrial plans the physical examination is a condition of employment and separate examinations for membership in the medical care plan are not required. Age limits, particularly in organizations providing care for subscriber dependents, are the only restrictions found in 16 percent of the plans having restrictions, and they are of course applicable almost wholly to the dependents. Fewer than 7 percent have only income limitations.

Of the plans having restrictions, nearly 30 percent have two of the three types mentioned above. Most of them, 70 percent, mostly industrial, combine entrance physical and age limitations; nearly 24 percent combine age and income, and a negligible number combine physical entrance and income. More than half of the medical society plans either set maximum income limits to membership or provide that those with more than a specified income may be charged extra for services rendered. The latter thus partake of the nature of cash indemnity plans.

Less than 1 percent of the plans having restrictions have all three of these types.

Benefits. Voluntary prepayment medical care plans generally provide restricted benefits, partly on account of the cost involved and partly in order to avoid unfavorable risks. Among the most common exclusions are the treatment for conditions existing before membership is acquired, mental diseases, tuberculosis, chronic illnesses, maternity care for the first 10 months of membership, nursing care, dental and eye service. These are not excluded in all plans, to be sure, but they are excluded in most, and where they appear they are usually included in only moderate amounts. It is difficult to summarize the services provided, but the following generalizations should be helpful.

Most of the persons eligible for care on a prepayment or reduced-fee basis are eligible for hospitalization and physician's care for medical and surgical cases in home, office, and hospital. This is true of 60 percent of those covered by the 229 plans summarized by Margaret C. Klem of the Social Security Administration. About 11 percent are entitled to hospitalization and physician's care in hospitals only, half of these for medical and surgical cases and the other half for surgical cases only, and about 23 percent were eligible only for hospitalized surgical care. Distinct variations appear as between the different types of plans.

Medical society plans in Washington and Oregon are the most liberal of all private plans in regard to benefits. They all provide hospitalization and physicians' services for medical and surgical cases in home, office, and hospital for all members. Other medical society plans are much less liberal, allowing for the most part only physicians' services for surgical cases treated in hospitals. It should be noted that nearly all persons in prepayment medical care plans who are not eligible for hospitalization under those plans belong to Blue Cross hospital service plans. Early in 1946, approximately 2 million Blue Cross members were also members of medically-sponsored prepayment plans for medical care. When medical societies outside of Washington and Oregon first began their plans, they provided very liberal benefits and low rates, but after some experience they gave up attempts to provide comprehensive benefits, arguing that the cost of comprehensive benefits makes such programs unacceptable to the public.⁴

⁴ Statement from the Council on Medical Service and Public Relations of the American Medical Association, in *Senate Hearings on S. 1606*, 79th Cong., 2nd Sess., Part 2, pp. 670-671.

Industrial plans are the next most liberal. Nearly 80 percent of the members are eligible for hospitalization and physicians' services for medical and surgical cases in home, office, and hospital. Private group clinics provide almost as broad coverage. About 77 percent of their subscribers are eligible for hospitalization and physicians' services for medical and surgical care in home, office, and hospital. Consumer-sponsored plans are least liberal, only about 58 percent of their subscribers being eligible for the broadest category of benefits, these being mostly in plans financed in part by the Department of Agriculture. The fact that a substantial number of these plans are in rural areas, where incomes are low, no doubt accounts for the meager benefits. Government-sponsored plans are as liberal as the industrial, all their members being eligible for hospitalization and physicians' services for medical and surgical care in home, office, and hospital.

Very little dental care is provided under medical prepayment plans. In the 229 plans reported on above, 54 percent of the participants were eligible to receive dental care, but only about 25 percent were eligible for substantial amounts and 40 percent of these were eligible on a reduced-fee basis.

Diagnostic x-ray service was available to 20 percent under prepayment plans and 6 percent more could get it at reduced rates; extractions were available to 13.1 percent, prophylaxis to 5.4 percent, and fillings to 5.3 percent. About 5 percent additional were eligible for each of the last three services on a reduced-fee basis. The total number of persons eligible for dental care declined slightly between 1943 and 1945, despite a substantial increase in the number of persons covered by medical care plans.

Medical society plans outside of Washington and Oregon supply practically no dental care whatsoever. Approximately one-third of those covered by industrial plans and private group clinic plans receive none. Nearly 20 percent of the participants in Washington and Oregon medical society plans, nearly 33 percent in industrial plans, and nearly 60 percent of those in consumer-sponsored plans are not eligible for dental care. More than 99 percent of the participants in governmental plans are eligible for dental care and practically all of them for substantial amounts.

Of the 5 million eligible for medical care in 1945, 2,200,000, or about 44 percent, were entitled to special-duty and visiting nurse service or both. Half of these were in industrial plans, 37 percent in

Washington and Oregon medical society plans, 7 percent in private group clinics, 5 percent in governmental plans, and 1 percent in consumer-sponsored plans.

Special-duty nursing service is more commonly available than visiting nurse service, and in 1945 was available to more than one-third of all those eligible for medical care. More than 80 percent of the participants in Washington and Oregon medical society plans were entitled to special-duty nurse service only, and 4.2 percent of those for visiting nurse service as well. Other medical society plans allowed neither. About 55 percent of the participants in industrial plans were entitled to receive special-duty nursing only, about 17 percent were eligible for visiting nurse service only, and nearly 10 percent were eligible for both. Private group clinics provided special-duty nursing only and nearly 40 percent of their participants were eligible for that. Governmental plans sponsored by the War Food Administration provided visiting nurse service only, but supplied that to all participants.

Physicians and Nurses Participating. The number of physicians who are associated with prepayment medical care organizations is not known. But in 1945, more than one-third of the practicing physicians of the country were so associated. A total of 764 were serving on a full-time and 6760 on a part-time basis. The others, approximately 36,000, were treating plan members under terms of the plans. The amount of time devoted to insurance patients by participating physicians is not known, but it could not average very high. During the war years, the number of physicians associated with these plans declined, but increased again after demobilization of the armed forces.

Industrial and group clinic plans are for the most part served by full- and part-time physicians. This results almost inevitably from the nature of those plans. The others are served primarily by participating physicians, and this is overwhelmingly true of all medical society plans, including those in Washington and Oregon. Medical society plans generally prorate available insurance funds among participating physicians on a fee-for-service basis in accordance with a schedule of fees established by the medical profession in the area served. There is free choice of participating physicians by the insured.

Nearly half of the prepayment organizations employ registered professional nurses on a full-time basis, and in addition some employ

special nursing service when needed. In 1945 there were 2092 full-time nurses employed by 229 prepayment medical care organizations, slightly fewer than were employed by 214 organizations in 1943. There would undoubtedly have been more but for the war-time shortage of nurses available to civilians. Some, but not many of these, worked in hospitals owned by the plans and a few gave visiting nurse service, but most of them simply did what is done by the nurse of a physician engaged in private practice.

Nearly 64 percent of the 2092 nurses on the staffs of the 229 organizations mentioned above were employed by industrial plans, and 64 percent of those were employed by industrial plans financed wholly by employees. Private group clinics were also well staffed with nurses, as were governmental and consumer-sponsored plans. Only a negligible number were employed in medical society plans, which had 1.2 percent of the total.

The American Nurses Association and the National Organization for Public Health Nursing have a joint committee on medical prepayment plans which suggested a nursing program that might be added to such plans.

The program would provide all types of nursing service when it is most needed; that is, special duty nursing service in the hospital or in the home for all serious conditions or for illness requiring continuous nursing care and a visiting nurse service in the home for a condition or illness requiring part-time skilled nursing care. The services proposed for inclusion in the contract are as follows for each individual covered: A maximum of 12 visits of one hour each in the home by a visiting nurse, and 9 periods of 8 hours each of special private duty nursing service in the hospital or home. The organization would pay \$1.25 for each visit by a visiting nurse, and \$5 for each 8-hour period of special private duty service. The total expense of these two services should not exceed \$60 per year for each individual. The cost of such service is estimated at approximately 40 cents a month for each individual subscriber and 90 cents a month for each family.⁵

MEDICAL SOCIETY AND BLUE CROSS PLANS

Late in 1945, the American Medical Association decided to promote aggressively the establishment of new, and the expansion of existing, medical care plans controlled by local medical societies.

⁵ Margaret C. Klem, *Hearings before the Senate Committee on Education and Labor on S 1606*, 79th Cong., 2nd Sess., Part 2, pp. 1101-1102.

Since then, such plans have increased in number and enrollment in them is larger than in any other type. They now constitute the major element in the voluntary movement, the element which will expand most rapidly, and it is desirable to make a brief separate analysis of them. The medical care plans established and operated by Blue Cross organizations are of the same general kind and are included here for analysis. By the beginning of 1947, there were 44 plans, counting Washington and Oregon as one each, and membership in them was approximately 4.5 million. On December 31, 1953, there were 76 plans and the total enrollment was 28.1 million, 14.5 million being subscribers and 16.6 million dependents. Approximately 62 percent of the enrollment was in 12 plans each having more than 500,000 members. The 11 smallest plans had an enrollment of 745,901, or 4.0 percent of the total.⁶

Benefits. Benefits provided are made to vary according to the type of contract offered. The most limited contract offers surgical and obstetrical care. Some of these contracts cover surgery and obstetrics only in a hospital, while others include office, and still others offer them anywhere. Since nearly all persons participating in these plans are also members of Blue Cross plans, the restrictions are not especially important. However, maternity benefits are usually available only after a waiting period of 9 or 10 months. Preexisting conditions are usually either excluded or covered only after six months or one year of membership. X-ray, anesthesia, and other services may or may not be included, depending usually on whether they are included in the companion hospital care plan. Nearly three-fourths provide x-ray, usually in limited amounts per admission or year. Some provide electrocardiograph and basal metabolism tests. More than one-third of all the plans operate under some variant of this general type of contract.

Half of the plans have more extensive coverage, including, in addition to surgery and obstetrics, hospital calls by physicians. Usually, only calls beginning with the fourth day of hospitalization are covered, the first three being paid for by the patient. Generally there are limits on the number of calls included, ranging from 17 to 42 per year.

⁶Louis S. Reed, *Blue Cross and Medical Care Plans*, Federal Security Agency, U. S. Public Health Service, 1947, Parts II, III, and IV; Associated Medical Care Plans, *Enrollment Reports*, *Blue Shield Plans, First Quarter 1948*, Table i, *Enrollment Reports*, 1953

A very few plans offer office and home calls in addition to the services included in the two contracts described above. Some of these require that the subscriber pay for the first two visits. But this type of coverage is not making any headway. On the contrary, the tendency is for medical society plans to abolish or restrict it, although the pressure of public opinion is in the opposite direction.

In the movement's early days, most plans had an overall dollar limitation on the total amount of benefits that would be provided under any one contract. But experience proved this to be unnecessary and at the beginning of 1954 only four plans were still following the practice.

Premiums. There is but little uniformity in the rates charged by the different plans. In part this is because of the differences in the benefits provided and the cost of those benefits as between the many plans. Within any one plan there may be different combinations of benefits offered as options. And membership may be on an individual or group basis. Furthermore, rate structures are constantly changing, to reflect increasing benefits and changes in the general level of prices.

For a family, the subscriber being covered as a member of a group, the monthly premium rate in 1953 for surgical benefits only ranged in 30 plans from \$1.00 to \$3.75, it was most commonly between \$2.25 and \$2.75. For contracts providing surgical and in-hospital medical benefits, the range in 51 plans was from \$1.75 to \$6.45; most commonly it was between \$2.50 and \$3.00. For the broadest coverage, namely surgical and general medical benefits, the range in 6 plans was from \$2.75 to \$7.60. The rates to single individuals covered as members of a group were of course lower. Non-group contracts, whether one-person or family, were somewhat higher and were payable on a quarterly or semiannual basis.

Physician Participation. Any licensed doctor of medicine is usually permitted to participate if he wishes to do so, and some plans also permit osteopaths to participate. In a few plans, only doctors of medicine who are members of their local medical societies are admitted to participation. In about half of the states with special enabling legislation, only doctors of medicine are allowed to participate.

But not all of those who are permitted to do so actually participate. There are relatively few plans in which as many as 90 percent of those eligible participate. Only where the medical society vigor-

ously pushes the plan do a substantial number of doctors take part. There are many reasons for nonparticipation. Some doctors are opposed to the prepayment principle, some object to service benefits, insisting that the cash indemnity principle be used, some fear the plan schedule will "fix" their fees to nonmembers, some object to certain details of the plan, some think they can do better for themselves outside the system, especially specialists whose differential skill is not adequately remunerated in plan schedules, and some are simply not adequately informed.

Three plans, California, Montana, and New Mexico, do not obligate themselves to pay benefits unless a participating physician is used, not even cash benefits to the subscriber. Of the others, eight obligate themselves to pay the same amount irrespective of whether or not the physician is participating, but usually only for emergency treatments. The others reserve the right to pay less where a nonparticipating physician is used, the rate being either 50 or 75 percent. However, not all of these plans adhere to this contract provision and they pay the same rates to all physicians. In some plans, payment to a nonparticipating physician in the same area is at a lower rate than to a nonparticipating physician not in the area. Amounts paid where nonparticipating physicians are used are the dollar allowances for services or the amounts that would have been paid to a participating physician, or the percentage specified where less is paid.

Service vs. Cash Indemnity. The extent to which benefits offered to subscribers are in terms of service to be rendered rather than a cash indemnity for specified contingencies is not as great in Blue Shield plans as in Blue Cross plans. The medical profession for the most part insisted on keeping its sliding scale of fees. In 1946 only four plans having 9 percent of the total enrollment were reported on a straight service basis, where the benefits promised were available to all subscribers without any additional charge, and this was substantially the case in 1954.

More than half of the plans provide a combination of service benefits and cash payments. For those members whose annual income falls below a specified level ranging from \$1500 to \$6000, but most commonly between \$2000 and \$3000, benefits are on a service basis. In recent years the general wage and salary levels have increased substantially, but the plans have been slow to raise their income limits to meet these increases. Participating physicians agree to

accept for their services the fees established and paid to the doctors by the plan. Members with incomes above the specified limit may be charged extra by the physician, the extent of the extra charge being determined by the physician in each individual case. This is another way of saying that for the higher-income group the plan grants dollar allowances for surgical and medical care. It is more common to find this benefit-cash rule applied to surgery than to medical care. It is worth noting that there is a tendency for physicians to accept from all member patients the fees established by the plan; this is especially true for members whose incomes do not greatly exceed the limits set in the plan contract.

There are some plans, relatively few in number, that do not offer any service benefits but are strictly on a cash indemnity basis. Such a plan has only dollar allowances. In 1952, 19 plans provided surgical coverage on this basis, 13 in-hospital medical care also, and 3 general medical care as well. In general, plans offering only cash indemnity allow a lower amount than do the service-cash plans for the same contingencies. The effect of a cash indemnity plan is to protect the physician's income rather than the patient's financial status, although it does offer the patient some protection.

Services are underwritten by physicians in more than half of the plans. The doctors participating agree that they will render the services promised irrespective of the condition of the funds. This has meant at times taking reduced fees. The enabling acts of some states require that the plans be underwritten by doctors. Physicians have the option of withdrawing from participation on short notice, from 15 to 30 days, or with no notice at all. It does not follow, to be sure, that any appreciable number of them would withdraw should a plan experience difficulties. In the indemnity plans there are no contracts with physicians, since service benefits are not sold.

Organization. Nearly all of the medical care plans are organized as corporations, but a few of them are mutual insurance companies and one is organized as a stock insurance company. The medical profession is definitely in control of the Boards of Directors. In 17 of the special enabling acts it is required that a majority be physicians, and in four states all or a majority must be approved by the state medical society, which is a component part of the American Medical Association. Most of these plans have public representatives on their Boards, but they are named by the medical profession. The Kansas enabling act has a provision, designed to protect the public

interest, which requires that the Governor appoint two members of the Board to represent the public. The plans organized by the Blue Cross hospital plans automatically have public representatives on their boards.

Like hospital plans, most medical care plans are not generally considered to sell insurance, but they are subject to a minor degree of supervision by the state insurance departments. As a rule they are exempt from state and local taxes.

Executive directors of medical plans are practically all laymen, and in many cases they are the same persons who administer Blue Cross hospital plans. Professional physicians have not generally proved to be good administrators. Usually a medical man, either on part or full time, interprets physicians' bills for service rendered and their reports and fulfills a liaison function with participating doctors. There is a medical committee to review questionable or doubtful physician claims.

In view of the medical profession's bitter opposition to compulsory health insurance on the ground that services would be controlled, the following quotation is of special interest.

In plans providing office and home calls, controls are necessary to protect the plan against bills for unnecessary services. The controls (which go beyond office and home calls) utilized by the King County Medical Service Bureau in Washington, may be cited as an example. This plan will not pay for an operation, except in emergency cases, unless there was prior consultation and the physician consulted agreed to the necessity for the operation. Tonsil and hernia cases will not be paid for unless the plan's medical director has himself examined the patient. In cases where the physician desires to recommend extensive laboratory and X-ray work, he must receive the medical director's approval before ordering these tests.⁷

In about half of the plans, the medical and Blue Cross plans are closely allied. Usually each is organized as a separate corporation, with separate Boards of Directors, but administration of the medical plan is performed by Blue Cross. In others both are separate, have different executive directors, but Blue Cross performs some administrative functions, such as enrollment and billing. There are seven medical care plans organized and operated by Blue Cross, and in these the management of the two is identical. There are some instances in which Blue Cross and medical plans are in competition.

⁷ Louis S. Reed, *op. cit.*, p. 194.

Operations. Data on operations of medical care plans are now adequate to present a summary view. Plans that blazed the way had little to go on in building their rate and service structures, and it was inevitable that some of them would experience difficulties. Those plans which offer comprehensive service benefits have in general experienced the greatest difficulties. It is quite probable that always there will be some plans that for one reason or another will have net operating losses. That has been true in the Blue Cross movement. However, the financial experience of the nonprofit medical care movement as a whole has been satisfactory.

Summary data on 75 plans at the end of 1953 show the following highlights: ⁸

Total assets	\$174,392,601
Income earned during year	316,923,789
Medical and surgical expense	254,485,869
Operating expense	35,632,184
Net income for year	26,805,736
Total reserves at year end	106,480,840

The ratio of medical and surgical expense to earned subscription income consistently remained slightly below 80 percent until 1953, when it was 80.3, indicating that a substantial degree of operating stability has been achieved. The ratio of operating expense to earned subscription income steadily declined, from 15.4 percent in 1947 to 11.24 percent in 1953, reflecting increasing size and improvements in efficiency. Operating costs are somewhat higher than in Blue Cross plans, partly because there are more billing and paying operations per case. The movement as a whole was in good condition with respect to reserves, having enough to pay benefits and operating expenses for 4.14 months. Only 10 plans had operating deficits for the year, totaling in amount less than 0.4 of 1 percent of earned income.

National Coördination. The American Medical Association has sponsored Associated Medical Care Plans, a nonprofit corporation consisting of approved state and local medical society prepayment plans. The principal function of this organization is to sponsor, coördinate, and assist approved state and local prepayment plans in

⁸ Associated Medical Care Plans, *Financial Reports, Blue Shield Plans for the Year 1953*.

such matters as methods, coverage, operations, and actuarial data. The corporation will also carry on research, advise on administrative policies and procedures, distribute literature and information to the public as well as to members, and attempt to bring about coordination and reciprocity among plans in the matter of transfer of membership, development of national enrollment among large enterprises, and contacts with governmental units and national agencies. Plans which conform to established standards are permitted to designate themselves as Blue Shield plans. State and local medical plans will, however, continue to be autonomous. This organization and the Blue Cross Commission have been put under a single director and will as far as practicable coordinate their activities.

The American Medical Association, through its Council on Medical Service, will formally accept medical society plans that conform to prescribed standards. Acceptance, which is normally for a period of two years unless revoked, grants the plan the right to print the Council's seal on the official papers and promotional or display material. The following standards have been prescribed:

1. The prepayment plan must have the approval of the state medical association—or if local, of the county medical society in whose area it operates.

2. The medical profession should assume responsibility for the medical services included in the benefits; the medical profession is qualified by education to accept responsibility for the character of the medical services rendered.

3. Provision should be made for a medical director acceptable to the county or state medical society, or a committee appointed by either of these groups, to adjust difficulties and complaints. The medical director or committee members may be paid on a *per diem* basis for the time involved in handling such matters.

4. There should be no regulation which restricts free choice of a qualified doctor of medicine in the locality covered by the plan who is willing to give service under the conditions established.

5. The method of giving the service must retain the personal, confidential relationship between the patient and the physician.

6. The plan should be organized and operated to provide the greatest possible benefits in medical care to the subscriber. Honesty of purpose and sincere consideration of mutual interest on the part of the subscribers, the physicians and the plans are presupposed as necessary considerations for successful operation.

7. The duties from subscribers through premium rates should be ade-

quate to provide for the benefits offered and the risks involved. In determining such factors the council will utilize the experience of those plans that are and have been operating successfully, but will not discourage experiments in other types of coverage provided such experiments are limited in scope and capable of scientific evaluation.

8. These benefits may be in terms of cash indemnity or service units. Where benefits are paid in cash to the subscriber it must be clearly stated that these benefits are for the purpose of assisting in paying the charges incurred for medical service and do not necessarily cover the entire cost of medical service, except under specified conditions.

9. Subscribers' contracts must state clearly the benefits and conditions under which medical services will be provided or cash indemnities paid. All exclusions, waiting periods, and deductible provisions must be clearly indicated in the promotional literature and in the contracts.

10. Promotional activities must be reasonable without extravagant or misleading statements concerning the benefits to the subscribers. In approving promotional material the council will endeavor to indicate the type of statements which are acceptable and the nature of those considered objectionable. It is not the function of the council to edit all copy word for word and sentence for sentence, but rather to indicate the general type of revision required in any given piece of literature. It expects the spirit and intent of such objections to be observed in the remainder of the copy not specifically criticized. Promotional activities will include any devices for informing the public or the profession.

11. Enrollment practices shall be based on sound actuarial principles such as will not expose the plan to adverse selection. Group enrollment is recommended until further experience warrants the acceptance of individuals.

12. It is understood that the plan of organization will conform with state statutes and that the plan will operate on an insurance accounting basis with due consideration for earned and unearned premiums, administrative costs, and reserves for contingencies and unanticipated losses. Supervision should be under the appropriate state authority.

13. Each accepted plan must submit periodic reports of financial and enrollment experience in the manner prescribed by the council.⁹

COMMERCIAL POLICIES

Commercial group medical care insurance is a relatively recent development, surgical contracts dating from about 1936 and medical

⁹ United States Senate, *National Health Program, Hearings Before the Senate Committee on Education and Labor on S. 1606*, 79th Cong., 2nd Sess., Part 2, pp. 555-556.

care contracts from 1940.¹⁰ They are sold by life and casualty insurance companies, about 87 percent of the surgical and 39 percent of the medical contracts being sold by eight life companies. Casualty companies have been more venturesome in the sale of medical care contracts.

It is estimated that at the end of 1953 approximately 18 million persons were covered by group policies and 13 million by individual policies. Data on how many persons were included under each of the major benefit combinations are not available. Consequently the extent of the protection offered cannot be indicated. Coverage in terms of numbers and benefits has been increasing rapidly.

A single one-year master renewable policy covering the group is made out to the employer or association. Where the entire premium is paid by the employees, there must generally be a minimum of 25 or 50 persons, and with at least 75 percent of them participating. Employers generally pay all or a part of the cost, and some companies will not write such policies unless they do, particularly if employees' dependents are included. New employees are included after what amounts to a probation period, usually of three months. This eliminates floaters and reduces the element of adverse selection. Protection continues only so long as the insured is a member of the group, employers usually paying the premium during temporary unemployment. Coverage ends with the month in which the employment relationship is terminated. Any individual, on leaving the group, may convert his group policy into a standard individual policy at standard rates.

Commercial companies have different types of contracts, similar in kind to those sold by nonprofit medical care plans.

The most limited is the surgical type of contract, with or without maternity benefits. This provides reimbursement of surgical and obstetrical fees paid, up to a maximum provided in a schedule. The reimbursement is made whether surgical care is received in or out of a hospital. Usually the maximum payable is \$150 for any one disability, although some companies sell policies that will pay different proportions of the schedule to fit the needs of different communities.

Premiums consist of a basic rate with loadings for the proportion of females in the group, and for dependents, with or without obstetrical benefits, and if obstetrical benefits are provided, then with

¹⁰ See Louis S. Reed, *Blue Cross and Medical Care Plans*, Appendix K, H. Ladd Plumley, *Budgeting the Costs of Illness*, chap. v.

immediate or deferred benefits. Thus the basic monthly rate for a group with less than 11 percent females might be 40 cents, for a family with obstetrical benefits excluded, \$1.20, with obstetrical benefits deferred for nine months, \$1.55, and with immediate obstetrical benefits, \$1.90, this dropping to \$1.55 after the first year.

Some companies sell surgical contracts which also provide medical calls in hospitalized cases. The amount allowed per call is specified, such as \$3.00 per day, for a maximum of say 50 days. The amount paid is the doctor's charges, but not to exceed the specified sums. For this there is a premium charge stated in terms of the number of dollars allowed per day of hospitalization, such as 3.5 cents per month. For a surgical call benefit of \$4.00 per day, the rate would be 4 times 3.5, or 14 cents per month.

There are now some companies that sell contracts covering medical calls, in hospital, office, and home. Here again, the contracts provide for the payment of specified dollar amounts, such as \$2 or \$3 for an office call and \$3 or \$4 for a home call. There is usually a two-visit deductible clause providing that the patient pays for the first two visits. Only one visit per day is paid for, but without limit on the number of visits per year. The premium charge could be 90 cents per month for a single employee and \$2.60 for a family, with a maximum of 50 visits per year for dependents.

A recent development in commercial insurance is major medical expense coverage, designed to meet the heavy cost of prolonged disability. Maximum benefits range from \$2500 to \$10,000. There is a deductible feature which requires that the insured bear a part of the cost. This type of policy may be used to supplement ordinary hospital, surgical, and medical care, or it may be used by persons who can afford to bear ordinary expenses but who want what is essentially catastrophe insurance. As yet very few have this coverage—somewhat less than 700,000 at the end of 1952.

CHAPTER TWENTY-TWO

CASH SICKNESS BENEFIT PLANS

PREPAID medical and hospital care plans are designed to provide all or part of the medical and hospital care resulting from illness or disability. Most victims of illness suffer in addition a loss of income through inability to work.

Many attempts have been made to secure enactment of laws providing cash payments for temporary disability resulting from non-occupational sickness and injury. Several states have now enacted such laws, and the Federal government has provided a system for the railroad industry. These laws are all integrated with unemployment compensation acts, and they may be thought of as extensions of the benefit coverage of those acts, in the sense that they pay for unemployment resulting from sickness and injury. Some integration is feasible and desirable because both systems cover the same workers, the same wages and pay rolls are used for benefits and taxes, the same machinery can be used for collecting taxes and paying benefits, duplication of benefit payments can be more easily prevented, and if one is desired a combined maximum benefit can be more easily administered. A description of the basic features of the laws follows.

THE RHODE ISLAND PLAN

By the spring of 1942, the Rhode Island Unemployment Compensation Fund had accumulated a substantial surplus, the balance in the Trust Fund account being about \$30 million. Deposits in the fiscal year 1941-1942 plus interest amounted to \$15,836,200 and withdrawals for benefits to only \$4,352,000. The ratio of benefits to collections from the beginning through June of 1942 was 38.9 for the country as a whole and 51.9 for Rhode Island. A part of the money in the Trust Fund was contributed by workers. Considerable

pressure for a sick benefit law developed, to be financed with the employee unemployment compensation contributions.

The state legislature acted swiftly in enacting the first American cash sickness compensation law. The bill was introduced on March 18, 1942, passed on April 23, and was signed by the governor and became effective on May 10, 1942. Benefits first became payable in April 1943, because that was the beginning of the uniform unemployment compensation benefit year. The system was integrated with unemployment compensation to the fullest possible extent, having the same administrative machinery, wage credits, and basic eligibility conditions and disqualifications wherever possible. It is worth noting that a process of differentiation between the two systems has set in.

Coverage. The Rhode Island cash sickness benefit system has exactly the same coverage as the state's unemployment compensation system, except that members of certain religious sects are not compulsorily included. Service for employers of four or more different individuals on 20 or more days in either the current or preceding year in all activities except agriculture, domestic service, government, and certain charitable and educational institutions is included. Between 250,000 and 285,000, or about 90 percent of the state's workers, are covered. Coverage is predominantly in manufacturing such as textiles, iron and steel, transportation equipment, with a fairly high ratio of women to men in the system as a whole—41 in October of 1943.

The problem of persons believing in faith healing was solved in 1943, by the simple device of exclusion. Any employee "who adheres to the faith or teachings of any church, sect, or denomination and in accordance with the creed, tenets, or principles, depends for healing upon prayer or spiritual means, in the practice of religion," is exempt from the act and excluded therefrom. Exemption is from taxes as well as from benefits. The employee must file with the state and with his employer affidavits in duplicate stating that he adheres to such a faith and disclaiming all benefits under the act. The affidavits must state the name of the employer, and must bear a certification by the president of the church concerned or by a healing practitioner. Employers may rely on the affidavit unless the Board administering the act informs them that it is not in order. New affidavits must be filed with each change of employment.

Benefit Amount and Duration. Weekly benefit rates are computed in the same way as for unemployment compensation, but different wage credit and benefit rate brackets are used. Total taxable wages earned in the base period are recorded. The base period consists of the four completed calendar quarters immediately preceding the benefit year. The benefit year in turn is an individual one and is defined as consisting of the one-year period beginning with the day on which a valid claim for disability benefits is filed. Benefit credits are assigned, based on the total taxable wages earned. The range is from \$34 for those with wage credits of \$100 to \$199.99, to \$364.50 for those earning \$1800 or more. In terms of percentages of base-period wages, this amounts to about 30 percent on the smallest earnings and decreases gradually to approximately 27 percent for those earning maximum creditable base-period wages. Total benefit credits determine the total amount of sickness benefits one can draw in the benefit year. The average weekly rate is based on the amount earned in the base-year quarter in which earnings are the highest. The weekly rates range from a low of \$10 to a maximum of \$25, depending upon the amount of high-quarter wages. But disability benefits plus workmen's compensation benefits, where disability results from occupational injury, may not exceed 85 percent of the worker's average weekly wage, or \$53 a week.

The maximum annual duration of benefits, which varies with the individual's employment experience, is the amount of base-period benefit credits divided by the weekly benefit rate, or 26 times the weekly benefit rate, whichever is smaller.

Eligibility requirements are simple. Wages in the base period must be at least 30 times the weekly benefit. There is a waiting period of one calendar week, resulting in an actual average waiting period of 11 days. This week must occur within the benefit year in which the worker is claiming benefits, or within the four consecutive weeks immediately preceding that benefit year. No week in which unemployment compensation or sickness benefits are payable under any other state or Federal law can be counted in the waiting period, but regular wages paid by an employer during the disability do not disqualify. Workmen's compensation benefits do not disqualify one from the sickness benefit but limit the total amount received; lump-sum settlements do not affect the worker's right to sickness benefits in any way, and the state cannot seek reimbursement from such lump-sum payments.

Taxes. Rhode Island was one of the few states in which an unemployment compensation tax was levied on workers. The rate on workers was 1.5 percent of wages up to a maximum of \$3,000 in any one year. It was decided that 1 percent of taxable pay roll would suffice to meet the cost of a cash disability benefit system, and that was the rate originally set. No additional taxes were levied, but two-thirds of the unemployment compensation tax on employees was diverted to the sickness fund, beginning June 1, 1942. That proved to be insufficient, and later the entire 1.5 percent was taken. Still later, in July of 1947, the rate on employees was reduced to 1 percent. Money received in taxes from employees is deposited in the sickness fund, but "without liability on the part of the State beyond the amounts paid into and earned by the fund." The state, in other words, does not underwrite the cost of the system. Money paid into the fund can be used only to pay sickness compensation benefits and the cost of administering them.

Provision is made to protect the solvency of the fund. When the Board administering the system believes that changes in the tax rate or in benefits must be made to protect the fund, it informs the Governor and the General Assembly and makes recommendations for action. The Governor may then declare an emergency and authorize the Board to modify the benefit scale, to increase the waiting period, or to make changes in the rules and regulations regarding eligibility for benefits. Changes made by the Board remain in effect until the Governor declares the emergency at an end, or until action is taken by the General Assembly.

Administration. The system is administered by the Rhode Island Department of Employment Security. Claims for benefits must be filed at public employment offices or at other designated places. These claims describe the worker, his employment, and his illness, and they must be mailed within three days of the date on the statements. They are passed upon by medical claims examiners. On the basis of information supplied by the claimant's physician, unless laboratory reports are required, the examiners determine the maximum number of weeks the claimant is likely to be incapacitated. Unless the claimant's physician reports a change for the worse and the determination is reviewed, no more benefits will be paid than those allowed until the claimant has been examined by a medical examiner and found still incapacitated.

The decision of a claims examiner is final unless the claimant or

other interested party requests a hearing within seven days. Appeal from a claims examiner's decision may be taken to an Appeals Tribunal, consisting of one or more impartial salaried referees, which shall affirm or modify the examiner's findings and decision. The Unemployment Compensation Board may permit any appeal to it, and must permit an appeal if the referee overrules or modifies the claims examiner's decision or a previous decision of his own on the same claim, and it may after a hearing affirm or modify or set aside any decision by a referee.

Beyond the Unemployment Compensation Board, there is a Board of Review, consisting of three persons appointed by the Governor, one representing employees, one the medical profession, and one the public, not more than two of whom shall be members of the same political party. Only aggrieved benefit claimants may carry appeals to the Board of Review, and only if the decision of the Unemployment Compensation Board is not unanimous. It may set aside or confirm the decision of the Unemployment Compensation Board. Appeal to the courts is permitted after all administrative remedies have been exhausted.

When an appeal is filed, any benefits payable will be paid only after the final decision has been made. However, if an examiner allows a claim and a referee affirms that decision, or if the Board affirms a referee's decision allowing a claim, the benefits for the period prior to the final decision are paid irrespective of any further appeal.

Regulations for hearings are laid down by the Board. The common-law and statutory rules of evidence need not be followed. A complete record of hearings must be kept, all testimony must be recorded, but it need not be transcribed unless necessary. Necessary records and reports may be required by the Board.

Expenses of administration are borne by the sickness compensation fund. In the original act, 1 percent of the amount received in taxes was allowed for administration. That proved to be wholly inadequate, and in 1943 it was raised to 3 percent. Even that proved inadequate, and since July 1946, 6 percent of collections has been authorized for administrative expenses.

There are penalties for making false statements or presentations in order to obtain or increase benefits or other payments, or to avoid coverage, or to avoid or reduce payments, each false statement or presentation being considered a separate and distinct offense.

Operations. There are some summary data available on the operations of the Rhode Island system, but the period covered was a troubled one and it is not possible as yet to indicate trends. Some of those data are shown in Table 71.

TABLE 71. Financial Data on the Rhode Island Cash Sickness Benefit System, 1942-1947 ¹
(In Thousands)

Financial Operation	1942-1943	1943-1944	1944-1945	1945-1946	1946-1947
Employee contributions	\$3873.9	\$4669.5	\$4557.2	\$4133.4	\$6684.6
Investment earnings	13.5	36.4	35.3	25.0	25.0
Benefits	900.0	4550.0	5050.0	4900.0	4715.4
Administrative expenses	17.3	126.4	134.9	151.2	277.2
Assets at end of year	2964.0	2980.5	2375.9	1468.0	3911.8

Taxes were collected under the system for nine months before benefits became payable. By the end of the first year, approximately \$3.9 million had been received in taxes and interest. Benefit payments amounted to only \$900,000 during the three months of that year in which they were payable. The year ended with a reserve of about \$3 million. During the second year, taxes and interest slightly exceeded benefits and administrative costs, and a very small amount was added to reserves.

Operations were not so successful the next two years. For 1944-1945, employee contributions and interest combined were approximately \$600,000 less than benefits and administrative expenses, and it was found necessary to sell some of the fund's investments. By the end of the year, the reserve had been reduced to \$2,376,000. In the year 1945-1946, there was a deficit of \$893,000, and investments were sold and the reserve decreased to \$1,468,000. The following year showed some improvement. Employee contributions increased appreciably and benefits declined slightly.

There were several reasons why the system developed deficits. For one thing, a decline in total pay rolls began in 1944 as a result of readjustments in war production. That resulted in declining taxes. Secondly, claims for benefits in the benefit years beginning April, 1943, 1944, and 1945 were based on preceding calendar years in

¹ Adapted from *Social Security Bulletin*, October 1947, p. 43, Table 3.

which wage rates and earnings were higher than in the benefit years. In other words, the wage levels on which benefits were based were higher than the wage levels on which taxes were being collected.

Perhaps more important than either of these was the fact that certain types of cases resulted in a heavy drain on the fund. The original law provided liberal benefits in cases of pregnancy, and allowed benefits to workers also in receipt of workmen's compensation benefits, and to workers who had retired from employment.

Much has been written about malingering under the Rhode Island system. The months in which benefits are highest are the spring and summer months of June, July, and August. Normally the sickness rate is higher in winter months. The high rate of summer benefit payments is said to result for several reasons. In the first place, there is a "letdown feeling" that follows the winter months, whatever that may mean. Secondly, there is a desire at that time for a vacation rest, and if sickness benefits can be obtained they will help finance the vacation. Of considerable importance is the fact that wage credits earned in the preceding calendar year become available as benefits beginning in April, which is the beginning of the uniform benefit year. This particular explanation is said to be supported by figures showing exhaustion rates of beneficiaries.

The Board may require a claimant to submit to a "reasonable" examination or examinations by experts appointed by it to determine his physical or mental condition. The provision appears to have been necessary. Table 72 summarizes some information on the operation of this phase of the law for the years 1945-1947 inclusive.

A substantial number of claimants called in for examination have failed to appear, and the percentage increased from 21.6 in 1945 to 23.8 in 1947. There has been a decline in the percentage of those denied benefits after medical examination, from 19.1 in 1945 to 9.7 in 1947. This decline is in part a reflection of the increasing percentage failing to appear for examination, as is the increasing percentage of claims allowed after medical examination. Very few of the claimants examined presented really doubtful cases, one way or the other. In 1946 the law was amended to require the Board to carry on campaigns to publicize the potential results of malingering.

Average actual duration of benefits in the first year was about seven weeks. For men it was slightly shorter than for women. About 40 percent of the women and 20 percent of the men exhausted all of their wage credits. Only 717 of the beneficiaries out of the 32,624

in that year had accumulated enough wage credits to last 21 weeks, the theoretical maximum duration. Three percent of the claimants had exhausted their credits at the end of five weeks, and 13 percent at the end of 13 weeks.

TABLE 72. Comparison of Cash Sickness Medical Examination Results in Rhode Island, 1945-1947²

Nature of Item	Number			Percent		
	1947	1946	1945	1947	1946	1945
Appointments actually scheduled	17,411	22,099	25,521	100 0	100 0	100 0
Claimants failed to appear—claims denied	4,152	5,028	5,526	23 8	22 8	21.6
Claims denied after medical examination	1,690	2,652	4,882	9 7	12 0	19 1
Claims held up pending laboratory tests	277	386	657	1 6	1 7	2 6
Claims allowed after medical examination	10,650	13,043	13,592	61 2	59 0	53 3
Claims allowed pending laboratory tests	448	673	657	2 6	3 1	2 6
Claims referred to Board	194	317	207	1.1	1.4	0 8

Average amount of benefits paid out during the first year was \$119. For men the average was \$123 and for women it was \$116. Recipients ranged in age from 15 to over 80 years. One 15-year-old girl collected \$165. Somewhat more than 2 percent were between 60 and 70 years old. There were 89 recipients who were 80 years or older.

The persistency of operating deficits led to substantial modifications in the original act during the January 1946 session of the Legislature. The contribution rate was raised from 1 to 1.5 percent of pay roll. This did not involve higher taxes, but merely a transfer to the sickness fund of all the tax levied on workers under the unemployment compensation law. The balance in the unemployment compensation fund had become huge, some \$70 million, and it was believed that no further contributions from employees needed to be made to that fund. Adding 0.5 percent of pay roll to the sickness

² *Twelfth Annual Report of the Rhode Island Unemployment Compensation Board, 1947, Table xx.*

fund increased collections substantially. In July of 1947, the tax rate was again reduced to 1 percent, and \$15 million was drawn from the Unemployment Trust Fund, leaving a balance of \$13 million to be utilized later.

Pregnancy benefits, which constituted a heavy drain on the fund, were limited to 15 weeks, and still later they were limited to a maximum of 12 consecutive weeks.

Action was also taken with respect to retired workers. It was provided that no payments should be made to any person who within a period of six months has not worked or applied for employment at a public employment office. It would still seem possible for aged persons not really in the labor market to draw benefits under the act, for the restrictions imposed are not severe. Mere application for employment would seem to suffice.

Payment of sickness benefits to persons also receiving workmen's compensation benefits resulted in a substantial drain on the fund. Furthermore, an anomalous situation developed. Over 25 percent of those receiving both benefits were getting more than their full-time normal weekly earnings. And those benefits were tax-exempt. The law was therefore changed to provide that no sickness benefit will be paid in excess of an amount which when combined with workmen's compensation benefits equals more than 90 percent of average weekly wages of the employee in his last regular employment. The law in this respect is still a most generous one.

Still another important change was made. Under the old law, a court decision interpreted ability to work as meaning ability to perform any work. This was amended to mean ability to perform one's regular or customary work. The effect of this amendment will be to increase the cost of benefits.

Finally, appeals machinery was revised. The Unemployment Compensation Board may reverse decisions of referees if the referee's decision overrules or modifies the findings of a claims examiner. Provision is made for a three-member Board of Review for appeals from the Unemployment Compensation Board. It is made up of representatives of workers, the medical profession, and the public, and passes only on appeals from the Unemployment Compensation Board which are not unanimous. A permanent advisory committee of seven members is provided. The Governor designates three to represent labor, two to represent the public, one of whom is selected

by the medical profession. The Chairmen of the House and Senate Labor Committees are ex-officio members. The Committee has broad advisory responsibility.

During the fiscal year ending June 1947, a total of 265,319 benefits were paid, totaling \$4.7 million. There was no deficit in that fiscal year. The higher tax rate brought in substantially more revenue, nearly \$6.7 millions. Benefits showed a decline of nearly \$200,000, reflecting changes made in the benefit provisions of the act in January 1946. Administrative costs increased somewhat, reaching \$277,200. Assets at the end of the year were quite substantial, being nearly \$4 million, not counting transfers from the unemployment compensation fund. There was more than \$1.5 million excess of employee contributions over benefits, and in addition \$15 million was transferred from the Unemployment Trust Fund.

During the calendar year 1952, a total of 31,397 new claims were filed, and 275,897 weekly payments were made, 42.1 percent to men and 57.9 percent to women. A total of \$6,234,960 was paid out in benefits, and the cost of administering the system was \$334,156. Total receipts for the year amounted to \$6,802,437, and \$5,940,408 of this came from taxes. There was a net increase of \$243,710 in the system's reserve. The balance in the reserve fund as of December 31, 1952, was \$34,721,644.³

THE CALIFORNIA PLAN

California was the second state to adopt a cash disability benefit plan. Like that of Rhode Island, it is integrated with the unemployment compensation system. The law was passed in 1946, was approved on March 5, and became effective May 21. Benefits, called unemployment compensation disability benefits, were to become payable one year after the effective date unless the Federal government authorized the transfer of employee unemployment contributions from the Federal Unemployment Trust Fund earlier than that, in which case they were to become payable 90 days after the transfer was authorized. The Federal government did authorize transfer of the funds, and benefits became payable on December 1, 1946. Employee pay-roll taxes levied under the state unemployment compensation law became payable into the cash disability benefit fund beginning May 21, 1946.

³ Rhode Island Department of Employment Security, *17th Annual Report*, 1952.

The state Senate Interim Commission on Unemployment Insurance studied the Rhode Island law and experience and as a result the California act excluded some of the high-cost items originally included in the Rhode Island system.

Coverage. Employments and persons covered, amount and duration of benefits, base period, wage requirements, benefit year, and claims procedures are the same for the disability benefit system as they are for the unemployment compensation system. A valid claim for one is a valid claim for the other in establishing a benefit year.

Coverage extends to employers of one or more, except for those excluded from the Federal tax, provided that pay roll for a quarter exceeds \$100. Between 2.5 and 3 million workers are included.

Benefits. Benefits are payable for mental or physical illness or injury which prevents one from working in his regular or customary pursuit. No payments are made for pregnancy, or for any disability arising out of or in connection with pregnancy for four weeks after termination. Benefits may not be received if the disability is compensable under the state's workmen's compensation law.

In order to qualify for benefits, several conditions must be met. A worker must have earned wages enough in covered employment during his base year to qualify for unemployment compensation benefits, namely \$300 in the base period, except that if more than 75 percent of base-period wages was earned in one calendar quarter, then earnings must equal at least 30 times the weekly benefit amount. There is a waiting period of seven consecutive days, not merely for the benefit year, but for each continued period of disability. A claim must be filed in the prescribed manner. And with the first claim there must be filed a medical certificate certifying to the existence of disability and estimating its duration. Medical doctors, osteopaths, and chiropractors are authorized to sign within the scope of their respective practices, dentists and chiropodists within the scope of their practice, and medical officers in federal medical facilities for patients in their facilities. A substitute certificate is permitted for members of religious sects which depend entirely upon prayer or spiritual means for healing. It must be signed by a duly authorized and accredited practitioner. No medical examination is required for members of such sects.

Weekly benefit amounts are based on the quarter of highest earnings, as specified in a statutory table. Where high-quarter earnings

are from \$75 to \$199.99, the benefit is \$10. This is the minimum. The weekly rate then increases by \$1 for each increase of \$20 in wages up to \$419.99 and \$1 for each \$40-wage increase thereafter, to the maximum of \$25 for those with high-quarter earnings of \$580 or more. The maximum duration of benefits is 26 times the weekly benefit amount or one-half of base-period earnings, whichever is the lower. Benefits are payable on a daily basis after the waiting period, and hospital benefits for 12 days at \$8 daily are allowed.

A claimant who is disqualified for unemployment compensation benefits because he voluntarily quits his job without good cause, or is discharged for misconduct, or is found guilty of misrepresentation in connection with a claim, or because he refuses to accept suitable work, is also presumed to be disqualified from receiving sickness benefits for the same period. However, if he can satisfy the administration that he is really sick or injured and that good cause exists for paying him benefits, then he may be paid. Workers engaged in labor disputes, those receiving unemployment or workmen's compensation benefits, those who refuse to submit to a required and reasonable physical examination are also disqualified. Any employee receiving "regular wages," i.e., wages paid directly by the employer out of his own funds during a period of disability, receives sickness benefits only to the extent that his benefit rate may exceed those "regular wages."

One may draw both compensation and disability benefits in the same year during different periods of time. But this is limited to a maximum of 1.5 times the total yearly amount of either benefit allowed. If, for example, a worker is eligible to draw the maximum of \$650 in sickness benefits, he may draw a total of \$975 in sickness and unemployment benefits during the year, although he may not draw the two concurrently.

Disability claimants have no out-of-state rights comparable to those in unemployment compensation. However, if a first claim is certified in California and approved, then benefits will be paid on continued claims certified by out-of-state licensed physicians and practitioners.

Taxes. The system is supported entirely by a tax on employees, amounting to 1 percent on the first \$3000 annual wages. The proceeds are placed in a Disability Fund administered by the state, and amounts not needed for current expenditures are invested in interest-bearing obligations of the Federal government and the state of

California. From 1936 to 1944, employee contributions to the unemployment compensation fund were at the rate of 1 percent and amounted as of February 28, 1945, to more than \$275.6 million. This exceeded the total amount paid out in unemployment benefits by approximately \$40 million. Interest earned on these employee contributions may be used, but not for administrative expenses. The balance in the Unemployment Compensation Fund at the end of 1947 was \$742 million. The amount remaining after transfer of all the employee contributions, should that be necessary, will still be adequate to meet the needs for unemployment compensation, at least for many years to come. Indeed, a Senate Committee had unanimously recommended in 1945 that if the employee contribution were not used to provide disability benefits, then it should be discontinued.

Administration. The system is administered almost wholly by mail. There is a central headquarters' office, with a small staff, about 30 early in 1948, and there are 16 district offices, which are combined in three field areas, with about 325 employees. These district offices are separate and distinct from unemployment compensation offices. Wage records are kept by the unemployment compensation division, which also supplies tabulations and statistics, office, fiscal, and personnel services, and the same appeals machinery is used by both. There is a public instruction and education unit to inform workers and employers of their rights and responsibilities under the act.

First claims, under the State Plan, are mailed directly to the central office where they are checked for timeliness of filing and validity of certification, and where a wage record determination is made. They are then sent to the appropriate district offices, which deal with claimants and doctors. In the district offices, the duration of disabilities are estimated, by laymen, and these are reviewed by medical officers. Checks are written in the district offices and sent to the claimants by mail. Such policing as is necessary is carried out through the district offices.

The solvency of the Disability Fund is made a special charge of the Commission. If and when the Commission believes that a change in contributions or rates is necessary, it must inform the Governor and Legislature immediately. The Governor may then declare an emergency and authorize the Commission to modify the benefit scale, increase the waiting period, or to change eligibility rules and regulations until the Governor declares the emergency over or the Legislature acts.

Voluntary Systems. Under the California plan, employers, a majority of their employees consenting, may establish and operate their own cash disability benefit systems, which are, of course, to operate within the framework established by the state. A majority of an employer's workers may also establish such a plan. This was allowed because of the long history of voluntary prepayment medical care plans in California, the vast wartime expansion in those plans, and the prevalence of group insurance. Unions at first were opposed to the voluntary plan feature, but after it was enacted they were quick to press for such plans in collective agreements.

In order to be approved, private voluntary plans must be more liberal in benefit provisions than the state system. This has been interpreted to mean that voluntary plans must provide greater rights in at least one respect, such for example as a shorter waiting period before benefits begin, and at least equal rights in all other respects. It is said that companies insuring voluntary plans universally ignore the base-year and benefit-year concepts, and this would make those plans more favorable.⁴ Voluntary plans contain a "shotgun clause" guaranteeing claimants at least the rate and duration they would have received under the State Plan.

Disability benefits paid under voluntary plans must be clearly labeled as "unemployment compensation disability benefits," and they must be shown separate and distinct from other benefits. This enables the state to make comparisons with the benefits paid under the State Plan.

If the voluntary plan provides for insurance, the insurance must be carried by an "admitted," i.e., an approved disability carrier, and the policy forms must be approved by the insurance commissioner. Otherwise the employer must put up bond or other security in lieu of insurance. A negligible number of employers have elected to become "self-insurers."

Furthermore, those operating voluntary plans must meet all requirements properly imposed by the Commission, such as reporting on each compensable disability and making comprehensive reports. Such plans must be effective for at least one year, and provide for automatic renewal unless terminated by the employer or by a majority of his employees, upon proper notice. The state may withdraw its approval after notice and hearing if it is believed that the plan

⁴ Interstate Conference of Employment Security Agencies, *Sick-Pay Benefit Legislation*, 1947, pp. 39-40.

may not be able to pay benefits in the future, or if insufficient security has been posted in the case of self-insurers, or for other good reason.

Any employee may at the time a voluntary plan is established choose to participate in it or to participate instead in the State Plan, even though a majority approves. If he does not elect the voluntary plan, then he must later be eligible not later than the first day of a calendar quarter after three months of employment. An employee hired after the plan is established may retain his membership in the State Plan, if he is covered by it. But he must be permitted to join the voluntary plan either on the day of employment or on the first day of any calendar quarter after he has completed not more than three months of employment. This allows a probationary period in some cases of from three to five months. Most plans allow membership immediately upon election.

Voluntary plans may not result in a selection of risks that is adverse to the State Plan. The principal factor considered is the number of women involved, for the incidence of illness among women is greater than among men. From 20 to 25 percent of the workers covered are thought to be women. The norm set is 20 percent. If an insurance carrier's voluntary plans have as little as 17 percent females, no new plan insured by that carrier will be approved unless it brings the percentage to 20 or more, and no plan will be approved for a carrier if it brings the percentage below 17. All self-insured are considered as though they were insured by one carrier.

Pay roll deductions on the wages of employees participating in voluntary plans must be separately accounted for. Where they are commingled, then in case of bankruptcy or insolvency such funds are subject to the same preference as state claims for unemployment compensation funds. The employer may, if he wishes, assume all or part of the cost of the voluntary system. No voluntary plan may, however, cost the employee more than 1 percent of his pay up to the specified \$3000 maximum. The employer continues to pay the unemployment compensation tax.

Employees covered by an approved voluntary plan or by the state plan who have built up rights to disability benefits under that plan, who are later separated from it, and who then suffer a compensable disability, are paid by the state fund. The cost of these benefits is equitably shared. Benefits are paid by the state from an "extended liability account" in the Disability Fund. This account is credited

with interest earned by the Disability Fund, including the average rate of interest earned by employee contributions to the Unemployment Trust Fund for 1944 and 1945. Should there be a deficit in the extended liability account at the end of any year, voluntary plans are assessed their share of the deficit, but not to exceed 0.3 percent of wages paid under voluntary plans in the year. The rate of assessment is the ratio of the deficit to all covered taxable wages. But unliquidated portions of a deficit are carried over to the succeeding year.

Any claimant whose claim is denied may appeal to the state, and the same appeal procedure and machinery is applicable to all covered employees. Should the state uphold the claim, it may if necessary enforce the decision by paying the claim and recovering the amount from the voluntary plan.

The existence of private voluntary plans entails greater administrative costs to the state. The voluntary plans bear that extra cost, which is prorated among them in accordance with taxable wages paid to their participating employees. The amount charged may be as much as 0.02 percent of taxable wages.

Periodic examinations of voluntary plans are made by the state to determine whether the provisions of the plans and the requirements of the law are being observed.

Operations. A brief review of operations under the act through the fiscal year ending in June 1952 may now be given.⁵ From May 21, 1946, through June 1952, for the State Plan, a total of nearly \$249 million had been received in employee contributions, only a small amount had been withdrawn from the Unemployment Trust Fund account, and a small amount had been received from other sources. Benefits paid from December 1, 1946, through June 1952 totaled \$128 million, and administrative costs for the entire period amounted to somewhat more than \$3 million. At the end of June 1952, there was a reserve for benefits of \$121 million and an adequate reserve for administration. In addition to this reserve there was a total of \$117 million in the Unemployment Compensation Trust Fund available for use if and when needed.

For the year 1947, a total of 137,619 first claims were filed under the State Plan, and the average weekly number of beneficiaries was

⁵ The data in this section are taken from *Social Security Bulletins*.

16,687. The ratio of collections to disability benefits in 1947 was 34. For 1952, the average weekly number of beneficiaries for the State Plan was 20,500, and 18,600 for private plans. The average weekly benefit for the State Plan was \$24.84

There were about 37,000 private plans in operation at the end of 1952, and they covered approximately 1.5 million workers. These plans are required by law to be more favorable than the State Plan. That they were is shown in the average weekly benefit amount, which for 1952 was \$30.84, or \$6 higher than for workers under the State Plan. Private-plan beneficiaries have shorter compensable disability periods than those under the State Plan—6 weeks as compared with 10.1 weeks in 1951. Only 9 percent of private plan claimants exhausted their rights in 1951 as compared with 20 percent under the State Plan, and they drew an average of 23.1 weekly benefits as compared with 22.8 for the State Plan beneficiaries.

Voluntary plans have so far been successful. The state agency believes that they have not presented any really serious problems and it is generally in favor of them. Employers are said to be rather on the neutral side, but insurance companies are said to have been their great protagonists.⁶

THE NEW JERSEY PLAN

The third state to enact a cash disability benefit law was New Jersey, whose act was approved on June 1, 1948. The New Jersey act differs in numerous respects from the Rhode Island and California acts just described, and from the railroad and the New York laws described in the following section. The New York Act, it may be noted here, differs from all the others in that it is modeled on the state's workmen's compensation law rather than on the unemployment compensation law.

Coverage. As in the other laws, coverage is the same as that of the unemployment compensation law, covering employers of four or more save in excepted occupations. Individuals who depend for healing upon prayer or spiritual means may elect out of the system. As of July 1952, approximately 1.5 million workers were engaged in the covered employments. Workers who shift from one covered employer to another, including employers having approved plans

⁶ Federal Security Agency, *California Disability Insurance Program*, 1948, p. 22.

of their own, remain protected. However, an individual who leaves covered employment loses his protection after two weeks.

Benefits.

Definition of Disability. Compensable disability is defined as that which results from any accident or sickness not compensable under the workmen's compensation law which results in total inability by the worker to perform his customary job. However, if the worker is unemployed at the time the disability occurs, he must be totally disabled from performing any work for pay. Benefits are not payable for any disability "due to pregnancy or resulting childbirth, miscarriage, or abortion." Furthermore, no benefit will be paid where the disability is due to "willfully or intentionally self-inflicted injury," or for injuries sustained in the perpetration of a "high misdemeanor." Benefits became payable for covered disabilities beginning on January 1, 1949, or later. The beginning date, it will be noted, is 7 months later than the date on which the Act was approved. Contributions from employees began on the date of approval.

Qualifying Conditions and Disqualifications. When the law was first enacted, a worker could qualify if during his base period he earned wages equal to at least 30 times his weekly benefit amount. Later this was reduced to 25. But beginning with 1953, an employment test was adopted. In order to qualify, one must have been employed at least 17 weeks during his base period, which is defined as the 52 weeks preceding the commencement of any period of disability. This is not a firmly established base period, but a "moving" one, newly established with every period of disability. The same type of period is found in the state's unemployment compensation law. The initial claim for benefits and medical certification of disability must be filed within 30 days after the disability begins, unless good cause for the delay can be shown.

An examination may be required not oftener than once a week, to be made by a legally licensed physician or by a public health nurse designated by the agency administering the act, this to be at no cost to the worker. Failure to submit to such an examination disqualifies one for any further benefits on account of that disability. No benefit will be paid for any period during which a claimant is **not** under the care of a legally licensed physician. A record of hospital confinement may be required in appropriate cases. Progress reports may also be required, if considered necessary in cases of pro-

longed disability when the disabled person is confined in his home rather than in a hospital.

A claimant who is disqualified for unemployment compensation because of a labor dispute is for the same reason disqualified for disability benefits, unless the disability began before the dispute. Unemployed claimants are disqualified for any disability beginning more than 26 weeks after the claimant became unemployed, if for that period he was also disqualified or ineligible for unemployment compensation. He is also disqualified for any week he is receiving workmen's compensation. His benefits are reduced by any amount received as full unemployment compensation, Federal old-age retirement benefits, or an employer pension.

Waiting Period. Benefits are not payable unless there have been seven consecutive days of disability. This waiting period must be served for each uninterrupted period of disability. A worker unemployed at the time his disability commences must have been unemployed at least one week in his unemployment compensation benefit year.

Amount and Duration of Benefits. The weekly benefit amount for employed workers is determined by taking two-thirds of the claimant's average weekly wage in the last 8 weeks of employment. For an unemployed claimant it is two-thirds of the wages received from the last employer who gave him at least 17 weeks of employment in his base period; and if no employer did so, it is two-thirds of the average of all covered wages received in the base period. But no weekly benefit rate is to be less than \$10 and none higher than \$30. For each day of compensable disability the rate is one-seventh of the weekly rate.

The maximum of benefits that will be paid in any period of 12 consecutive months is limited to three-fourths of a worker's "base" weeks multiplied by his weekly benefit amount. A base week is defined as one in which a worker receives at least \$15 in covered employment. There is a minimum of 13 weeks for benefits and a maximum of 26.

For those who are unemployed when disability commences, combined disability and unemployment benefits may not exceed 150 percent of the duration they would be entitled to under either one of the two programs.

If the wages an unemployed claimant receives in any week plus \$3 is less than his weekly benefit amount, he may receive the difference. A claimant employed at the time his disability commences

may not receive benefits for any week in which he works for pay, and if his employer continues to pay him wages during his disability, then his wages and benefits combined may not exceed his "regular" weekly wages just prior to his disability. Disability benefits are also reduced by the amount of any Federal Old-Age and Survivors Insurance primary benefit or pension from his employer.

Taxes. New Jersey was one of the few states that required employees as well as employers to make contributions to help finance the unemployment program. The cash disability program was originally financed by part of the contribution which employees had made for the unemployment compensation program. The rate for disability benefits at first was one percent of wages, but later that was reduced to three-fourths of one percent, and beginning in 1953 it was still further reduced to one-half of one percent.

Employers were required to contribute beginning on January 1, 1949. Those who do not contract out of the state system by establishing an approved plan of their own pay at the rate of one-fourth of one percent, on the first \$3000 of individual wages paid. However, there is a merit rating system, to be described below, which makes it possible for employers with a favorable experience to have that rate reduced. Employers who establish their own disability benefit plan, whether insured with a commercial carrier or self-insured, which must of course be approved by the state, are permitted to collect the amount which their covered employees are required to contribute. Those employers must bear the amount by which their total cost exceeds their employees' contributions. They are not required to contribute to the State Plan, except as they are assessed from time to time amounts needed to replenish the special fund from which benefits are paid to workers whose compensable disability begins while they are unemployed.

Three accounts are established. There is a State Disability Benefits Fund, which is credited with all worker and employer contributions, all interest and earnings from investments in that fund, and all assessments, fines, and penalties collected under the act. Deposited in it also are all employee contributions withdrawn from the state's account in the Federal Unemployment Trust Fund, \$50 million authorized in the original act. The funds are used to pay disability benefits and refunds, and any balance is invested in obligations legal for savings banks. The Fund is managed by a Board of Trustees, consisting of the State Treasurer, the Secretary of State, the Com-

missioner of Labor, the executive director of the commission administering the act, and the State Comptroller.

An Administration Account is established. It is credited with 8 percent of current contributions paid into the Disability Benefits Fund, but it is not credited with any part of employee contributions withdrawn from the state account in the Federal Unemployment Trust Fund. This account is also credited with the proceeds of assessments made against employers having voluntary plans to meet the additional administrative costs incurred to supervise those plans. The account is charged with the cost of administering the act, and with the cost incurred by the Board of Trustees in administering the Disability Benefits Fund.

The third account is known as the Unemployment Disability Account. This account is charged with all benefits paid to workers whose compensable disability commences while they are unemployed, whether they were covered by the State Plan or by a private plan before they became unemployed. Benefits paid from this account are not considered in experience-rating calculations described below. The account is credited with the interest earned by the employee contributions withdrawn from the Federal Unemployment Trust Fund and deposited in the State Disability Benefits Fund, and with the proceeds of assessments made against employers when the account shows a deficit. If a deficit appears, all covered employers are assessed a rate on their taxable wages equal to the ratio of the deficit to all taxable wages for that year, but in no event is the assessment to exceed two one-hundredths of 1 percent of taxable wages in any one year.

Experience Rating. Since July 1, 1951, the tax rates paid by individual employers in the State Plan have been determined in accordance with an experience rating system. Each employer has a disability benefit account, which is credited with all of his contributions to the system and those of his employees as well. Benefits paid to his employees are charged to his account. The excess of contributions over benefits may be considered his disability reserve, and the ratio of that excess to average annual pay roll may be called his disability reserve ratio. Only employers who have been covered for at least two full calendar years and whose accounts have been credited with at least \$1500 in employer and employee contributions participate in the experience-rating system.

Prior to July first of each year, the commission administering the law makes preliminary determinations of the rates to be paid by employers who qualify for experience rating. But no employer's preliminary rate may be increased by more than one-tenth of 1 percent of taxable wages, or decreased by more than two-tenths, from the preliminary rates established by the same process during the preceding year.

For those who do not qualify for experience rating, the rate is one-fourth of 1 percent of taxable pay roll.

An employer who has met the minimum requirements and who in addition has a disability reserve of at least \$500, will be charged preliminary rates on his taxable pay roll as follows:

If the Reserve Equals or Exceeds:	But Is Less Than:	The Preliminary Tax Rate Is:
1.00 percent	1.25 percent	0.20 percent
1.25 percent	1.50 percent	0.15 percent
1.50 percent		0.10 percent

Anyone meeting the minimum requirements but whose reserve is less than \$500 plus 1 percent of his average annual pay roll is assigned the standard rate of one-fourth of 1 percent, as are those whose accounts show a deficit of not more than \$500.

But for those whose accounts show a deficit of more than \$500, penalty rates based on the ratio of the excess over \$500 to average annual pay roll are assigned, as follows:

If the Deficit Above \$500 Equals or Exceeds:	But Is Less Than:	The Preliminary Tax Rate Is:
0.00 percent	0.25 percent	0.35 percent
0.25 percent	0.50 percent	0.45 percent
0.50 percent	0.75 percent	0.55 percent
0.75 percent	1.00 percent	0.65 percent
1.00 percent		0.75 percent

These are preliminary rates and are subject to change. The final determination depends on the status of the Disability Benefits Fund as of the end of the preceding calendar year plus contributions received and minus benefits paid during January with respect to employment and disability in the preceding calendar years.

If the amount in the Disability Benefits Fund exceeds the amount of employee contributions withdrawn from the Unemployment Trust

Fund (\$50 million withdrawal authorized in the original act) plus the amount in the Unemployment Disability Fund (from which benefits are paid for disability commencing during unemployment), the difference is expressed as a ratio of the total of taxable wages on which contributions were paid to the State Disability Benefits Fund through January 31 with respect to employment during the preceding calendar year.

If the percentage determined as above, i.e., the excess in the State Disability Fund over the amount withdrawn from the Unemployment Trust Fund plus the amount in the Unemployment Disability Fund, equals or exceeds $1\frac{1}{4}$ percent of taxable wages, the final employer rates shall be the preliminary rates for experience-rated employers with penalty rates, i.e., above 0.25 percent. Experience-rated employers with standard or reduced preliminary rates shall have their rates reduced by that percentage, to the nearest five one-hundredths of 1 percent. But no final rate so reduced can be less than one-tenth of 1 percent.

If the percentage exceeds three-quarters of 1 percent but is less than $1\frac{1}{4}$ percent, the preliminary rates stand unchanged.

But if the percentage is less than three-quarters of 1 percent, the preliminary rates are increased by the difference between three-quarters of 1 percent and what the percentage actually is, to the nearest five one-hundredths of 1 percent. But no employer given a below-standard preliminary rate shall have his rate increased to more than 0.25 percent, and no employer with a standard rate, i.e., 0.25 percent, shall have his rate increased to more than 0.50 percent, and no employer with a penalty rate shall have his rate increased to more than 0.75 percent.

If there is no excess, or if there is a deficit, then the final rate shall be 0.75 percent for all employers.

Private Plans. As in California, any covered employer may establish a private plan and in that way contract out of the general State Plan. But that can be done only with the approval of the commission administering the state disability benefits law.

Conditions for Approval. In order to be approved, a private plan must: (a) cover all the employer's workers, except that with the approval of the commission a class or classes may be excluded, provided the exclusions do not result in a substantial selection of adverse risks to the State Plan; (b) eligibility requirements for benefits are to be no more restrictive than those in the State Plan; (c) weekly

benefits must be at least equal to those of the State Plan; (d) no greater contribution may be required from employees than under the State Plan; (e) coverage must extend for at least two weeks after separation, unless a worker is employed by another covered employer; (f) a majority of the employees must have agreed to the plan in writing, if they are required to make contributions under the plan.

Employers already having voluntary plans, under which they make contributions to the cost, at the time the law became effective were permitted to continue them until the time when the employer has the right to modify the benefits or to discontinue the plan or to discontinue his contributions to it, regardless of the requirements of the law. While such a plan is in existence, the workers covered are not eligible for benefits under the State Plan.

Employers may if they so desire, establish supplementary plans providing additional benefits to any class or classes of employees and collecting additional voluntary contributions from employees with respect to those additional benefits.

Records as prescribed by the commission must be kept by the employer and made available to inspection by the commission's authorized representatives. Reports as required by the commission must be submitted.

Termination of Private Plans. The commission may terminate a private plan if a majority of the employees covered have elected in writing to discontinue the plan, and if 10 percent of them sign a petition to discontinue, the commission will require the employer to conduct an election by ballot to determine the issue, but not more than one such election in any 12-month period will be required. An employer may not himself terminate a plan until at least 30 days' notice has been given to the commission and notices conspicuously posted for workers to observe, except that the commission may for cause permit termination in less than 30 days. The commission may itself, after notice and hearing, withdraw its approval if it finds there is danger that benefits will not be paid, or that the security posted by the employer, if he is a self-insurer, is insufficient, or for other good cause. The commission may withdraw its approval if a plan is so administered or applied that the employer or a union is deriving a profit from its operation.

Termination of a private plan for any reason does not affect the right of a covered worker to benefits for a disability commencing

prior to termination, and employees formerly covered by a terminated private plan immediately become eligible for benefits in the State Plan. But no employee is entitled to benefits from the State Plan while he is covered by a private plan. Security for the payment of benefits is provided by carriers and employers.

Review. Any employee covered by a private plan may appeal to the state commission to investigate and hear his claim for benefits, if he cannot settle with his employer or the employer's insurer. After such a hearing, a determination of facts will be made and an order made disposing of the issues, and that order will be final and binding upon all parties, except that appeal to the courts is permitted, and the cost of transcribing the proceedings and preparing the record for a court hearing constitutes a cost of administering the act.

Taxes. Employers having private plans and their covered workers are not required to make disability benefit contributions to the State Plan. Such employers may, if they care to do so, pay the entire cost of their private plans. However, they may levy a charge against their covered employees, but the rate may not exceed three-fourths of 1 percent of taxable wages per year, which is the rate levied on employees covered by the State Plan.

As noted above, employers having private plans are assessed the extra cost to the state of administering the private plan system, and they are also subject to assessment to make up any deficit developing in the Unemployment Disability Benefits Fund, from which are paid benefits to covered workers whose compensable disability commences while they are unemployed.

THE RAILROAD SICKNESS INSURANCE PLAN

In 1946, Congress amended the Railroad Unemployment Insurance Act to provide for the payment of cash sickness and maternity benefits, the amendment becoming effective beginning July 1, 1947. The cash sickness benefit plan is integrated with the unemployment insurance system, and wherever possible the provisions of the two are identical. Sickness is considered to be in effect unemployment. One qualifies for sickness or maternity benefits in exactly the same way as for unemployment benefits. The basic condition of eligibility is earnings in railroad employment of at least \$400 in the base year. Benefits were first payable in July 1947 to those who had such earnings or were otherwise qualified in the base year 1946. The benefits

are financed by income from a pay-roll tax which is paid by the carriers. It is believed that proceeds from that tax will suffice to meet obligations for unemployment, sickness, and maternity. Since the general framework of the railroad unemployment insurance system has been described in Chapter 13, it will not again be treated in detail at this point.

Benefits. As with unemployment, sickness benefits are payable for each day of sickness in excess of seven in the first fourteen-day registration period and in excess of four days in each subsequent registration period in the benefit year. A day of sickness is defined as any calendar day in which an employee is unable to work "because of any physical, mental, psychological, or nervous injury, illness, sickness, or disease," with respect to which no remuneration is payable or accrues to him, and for which a prescribed statement of sickness has been properly filed within such reasonable period, not in excess of 10 days, as the Board may prescribe. A maximum of 130 days of sickness benefits is allowed, at the unemployment insurance rates, in any one benefit year.

A statement of sickness is executed by the worker's physician or by any individual who is duly authorized by the Railroad Retirement Board to do so. Only one such statement must be executed for each illness. It must be executed in time to be received by a Board office and not more than 10 days after the first day claimed as a day of sickness. Persons who solicit the execution of such statements, or who make false or misleading statements, or who refuse to submit required reports and records, or who have engaged in malpractice or other professional misconduct, may be disqualified by the Board from executing the statements. An acceptable statement of sickness provides evidence needed on the days of sickness suffered by an individual and is considered as initial proof of disability sufficient to certify for payment of a claim. Attending physicians may be requested by the Board to submit progress reports and information regarding patients. Days of sickness and days of unemployment may not be combined in order to qualify for either sickness or unemployment insurance benefits.

Persons receiving retirement benefits under the Railroad Retirement or Social Security Act, or unemployment, maternity, or sickness benefits under any other Federal or state law, or any other social insurance payments under a Federal or state law, including workmen's compensation benefits, are disqualified from receiving sickness

or maternity benefits at the same time under this act. However, if retirement, Social Security, or workmen's compensation payments are lower, the sickness benefit will be reduced by their amount. But receipt of a veteran's disability pension does not disqualify one from also receiving the sickness benefit, even if it is a pension for total disability. For such a pension is neither a "sickness benefit" nor a "social insurance" payment. Receipt of sickness benefits under a nongovernmental sick benefit plan does not constitute a disqualification; nor does leaving work without good cause, refusing to accept suitable work, or participating in strikes.

The Board may require individuals claiming or receiving sickness or maternity benefits to undergo examinations, physical, mental, or otherwise, by such qualified doctors as it may prescribe, although such times and places must be reasonably convenient for the employee. Unreasonable refusal to take, or willful obstruction of, an examination disqualifies one for benefits. The Board may contract with and pay doctors, hospitals, clinics, or other persons to make examinations of employees claiming benefits and to execute for those employees the required statements of sickness. But the cost of making the examinations and statements will be deducted from the benefits paid on the basis of the claims made.⁷ The Board does not have power to regulate the charges made by doctors for filling out statements of sickness, and it does not approve or disapprove those charges.

An application for either sickness or maternity benefits must contain a waiver of any doctor-patient privilege that the employee may have in respect to the sickness or maternity period upon which the application is based. But information so acquired will not be disclosed by the Board except in a court proceeding relating to any claim for benefits by the employee under the Act.

In order to receive maximum benefits, an application for sickness benefits must be filed within 10 days of the beginning of an illness or injury. Should one be filed later than that, the claimant may lose one or more days of benefits to which he might have been entitled. A new application must be filed for every new illness or injury, as contrasted with a single application during one benefit year for unemployment insurance. If the estimated or probable duration of

⁷ The Board has not made any such contracts. There is printed on the Statement of Sickness the following warning: "The Board is not liable for any charge in connection with completing this statement."

disability is seven days or more, the Board will send the applicant information concerning his benefit rights, and also a claim form which must be filled out and signed at the end of the registration period. The claim form is for a registration period of 14 days, and a new claim form must be submitted for each registration period. If the application indicates that disability will continue for more than one registration period, the Board automatically sends out additional claim forms as indicated. For the first registration period, benefits are paid only for days of disability in excess of seven, and for subsequent periods in the benefit year they are paid for days in excess of four, as in the unemployment insurance program.

Cash sickness benefits are payable for disability resulting from occupational injuries or disabilities, regardless of whether or not the employer or anybody else is liable to pay damages on their account, unless the injury is covered by a state or Federal workmen's compensation law. Should damages be received by the injured employee or other person, through legal action, compromise, settlement, or otherwise, the Board may recover the amount paid out in sickness benefits for the same disability. This would not, of course, apply to proceeds from health, sickness, accident, or similar commercial insurance policies.

By filing a notice with the person against whom a right to recover damages exists, the Board secures a lien against the right or claim, on any judgment obtained, and on any sum or damages payable, to the extent of the amount it paid out in benefits. When settlements are made or damages paid in such cases, the amount of the benefits received by the worker is taken out and sent to the Board. Furthermore, if the liable person knows that sickness benefits have been paid, then he may be liable for the proper amount even though the Board has not served notice on him.

Thus an injured employee may elect to sue his employer under the Federal Employers' Liability Act or to take the sickness benefits, or both. He has nothing to lose by taking the sickness benefits, and by doing so is assured of a small current income for a short time. Indeed, the benefits provided by this act make it possible for the injured worker to hold out longer for what he considers a better settlement. The Board itself may not bring suit against the person liable to pay the damages. Should workers in large numbers fail to sue for damages or negotiate settlements, the Government might find itself engaged in many suits in order to protect the fund. In practice,

the Board takes no part in the settlement of damages except to file notice of a possible lien.

Maternity Benefits. Special provision is made for maternity benefits, which are payable to qualified women employees only and not to the wives of insured men. Furthermore, maternity benefits are in addition to the regular sickness benefits provided. A qualified female employee may receive both sickness and maternity benefits in the same benefit year, but not, of course, at the same time. Receipt of maternity benefits does not reduce the amount of sickness or unemployment benefits that a woman might otherwise be eligible to receive.

A "maternity period" is established, which begins 57 days before the expected date of birth and ends with the 115th day after the period begins, or with the 31st day after the date of birth, whichever is later. Benefits may not, however, be paid for more than 84 days before the date of birth. Thus the maximum number of days for which maternity benefits will be paid is 116.

Maternity benefits are paid to qualified employees for each day of the maternity period, and not, as with other sickness and with unemployment benefits, for all days in excess of seven in the first registration period and of four in subsequent registration periods. Furthermore, for the first 14 days in a maternity period and for the first 14 days after the birth of a child, the benefit rate is 1.5 times the regular rate payable for sickness. This results in the payment of benefits equal to 130 days, which is the maximum allowed for sickness or unemployment in any one benefit year.

A maternity period which continues from one benefit year into another is not affected by the expiration of the benefit year. The benefit rate and the number of days for which benefits are paid continue into the new year. An employee who is not qualified to receive benefits when her maternity period begins but who qualifies for them in the next benefit year may receive payments for that portion of her maternity period which extends into the new year.

A "statement of maternity sickness," providing evidence of pregnancy and giving the expected date of birth, must be filed by the woman's physician or by some authorized person. Later, the actual date of birth must be specified.

Research and Recommendations. The Board is to engage in and conduct research projects, investigations, and studies concern-

ing the cause, care, and prevention of accidents and disabilities and related subjects, and is to recommend such legislation as it may deem advisable as indicated by its findings.

Operations. The railroad sickness insurance program has been in operation since July 1, 1947. There has not been sufficient experience to reveal major trends, but the following summary review of operations is suggestive.

In the first year of operations, 149,000 persons excluding maternity beneficiaries, or 6.6 per 100 of the 2,270,000 qualified workers, were paid an average of \$176, and a total of \$61.4 million. The average daily benefit rate for that year was \$4.12.

There has been but little change in the number of beneficiaries since then. The benefit year 1948-1949 saw 151,200 on the roll, the year 1951-1952 recorded only 130,000, and for 1952-1953 the number was estimated at 147,400. There has been more change in the number of beneficiaries per every 100 qualified employees. For the six-year period ending in 1953, the low was 6.6 in 1947-1948 and the high 8.1 in 1952-1953. Average length of sickness, including uncompensated time, was lowest in 1947-1948, with 65 days; it reached 73 in 1949-1950 and 1952-1953. Until 1952-1953 the average daily benefit rate changed only little, rising slowly from \$4.12 in 1947-1948 to \$4.28 in 1951-1952. But a marked increase in benefits was then legislated. The lowest rate was raised from \$1.75 to \$3.00, others were increased as much or more, and two new rates were added, one of \$7.00 and one of \$7.50. The average daily rate paid in 1952-1953 was \$6.09.

The rate of benefit exhaustions has fluctuated considerably. It was lowest in the first year, when 9.1 per 100 beneficiaries drew the maximum number of days of benefits allowed, namely 130. The next two years, 1948-1949 and 1949-1950, showed increases, to 11.0 and 13.1. Thereafter the rate again declined, to 12.8 in 1950-1951 and to 10.6 in 1951-1952. For the benefit year ending in 1953 it reached 14.3, the highest to that date. For the five years 1948-1952, as many as 87 percent of all beneficiaries did not exhaust their rights, 11 percent exhausted them once, and only 2 percent exhausted them in two or more years.

The pattern of disability does not vary much from year to year except in the event of an epidemic. For the five years ending in 1952, about 46 percent of the beneficiaries had been on the benefit roll in only one year. In any given year only a small percentage, roughly 13, have been on the roll in both earlier and later years.

Fractures have been the most common cause of disability, accounting for about 6.5 percent of all benefits. Arthritis and rheumatism run a close second, accounting for nearly 5.5 percent. Arteriosclerotic and degenerative heart diseases, hypertension, and ulcers together account for nearly 12 percent. The duration of illnesses is high. Tuberculosis and general arteriosclerosis have a light incidence but a heavy duration—200 and 280 days respectively.⁸

The Railroad Retirement Board makes sample checks on claims for disability benefits. From August through December of 1947, a total of 2115 field visits were made, mostly in September, of cases where a doctor's findings did not appear conclusively to support his diagnosis. Interviews were held wherever possible with the claimant, his employer, his doctor, and in some cases with other persons who had knowledge of the case.⁹

The results of those interviews suggest that the system is working reasonably well. There were only six cases in which possible indications of fraud were found, and only nine where there was evidence of possible malingering. A total of 94 cases were found in which wages were payable for one or more of the days of claimed disability, but the wages had not yet been paid and there was no evidence that fraud was intended. In 24 cases it was found that benefits might later be recovered from work injury or other damage settlements. In 84 cases, special medical examinations were scheduled to determine more accurately the extent and probable duration of the disability.

THE NEW YORK PLAN

New York enacted its law in 1949, to become effective in 1950. The plan differs from others in that it is modeled after workmen's compensation rather than unemployment compensation, and it is administered by the State Workmen's Compensation Board rather than by the agency administering unemployment insurance.

Coverage. Employers who for 30 or more days employ 4 or more workers are covered. Maritime workers and public employees are excluded, although both of these groups are covered by unemployment insurance. Excluded employers may voluntarily elect coverage, but at least 50 percent of their employees must agree, unless the employer pays the tax levied on employees. Voluntary coverage may

⁸ *The Monthly Review*, September 1953, p. 167

⁹ *Ibid.*, February 1948, pp. 22-24.

be discontinued on 90 days' notice. Individual workers otherwise covered are permitted to elect out of the system on religious grounds.

Benefits. Disability occurring during employment is defined as inability to perform one's regular duties or other duties which the employer may offer at the worker's regular wages and which the injury or disability does not prevent the worker from performing. Disability resulting from occupational injury is excluded, being covered by the workmen's compensation law.

To be eligible for benefits, an employed worker must have been at work for 4 or more consecutive weeks in a covered employment. Eligibility extends for 4 weeks after covered employment is terminated, but not beyond the fifth day after termination if the worker is gainfully employed by a noncovered employer. As long as the worker moves among covered employers, his eligibility is protected. An unemployed worker who is eligible for and receiving unemployment compensation benefits becomes eligible immediately upon returning to work for a covered employer. Regular part-time workers become eligible on the 25th day of work for the same covered employer.

Benefit payments begin with the eighth consecutive day of disability. Successive periods of disability caused by the same or by a related injury or sickness are considered a single period only if they are separated by less than three months. The waiting period of 7 days applies again when there are three or more months between periods of any one disability, and for each different disability.

The benefit rate is one-half of the worker's average weekly wage, with a maximum of \$30 and a minimum of \$10. But if the average weekly wage is less than \$10, the benefit is the amount of the average weekly wage. Compensated disability for less than one week is the benefit amount divided by the normal number of days worked each week times the number of days of disability.

The average weekly wage is the average of total wages received from the last covered employer for the 8 weeks, or portion thereof, immediately preceding and including the last day worked before the disability began. If the worker has not worked 8 weeks for his last employer, the average may be of his total wages from all employers in the 8-week period. Thus the rate is based on most recent earnings rather than on the more remote base period used for unemployment insurance. The Board administering the Act may pre-

scribe other procedures for any class or classes, and it may authorize reasonable deviations from established procedures.

Duration of benefits is not to exceed 13 weeks during any period of 52 consecutive weeks. No benefit is paid for any period when the worker is not under the care of an authorized physician. Injury or sickness willfully caused by the worker or by another worker, or resulting from an illegal act, is not compensable. Nor are benefits paid for any day on which a worker is employed for pay or profit, or for any day on which a worker is entitled to sick leave with pay from his employer or to benefits from a fund to which the employer has contributed, where the pay or benefit is equal to or greater than the benefit provided by the law. No benefits are paid for disability due to an act of war. No benefit is paid for any day on which a worker is disqualified for unemployment compensation benefits, or would be disqualified if he were eligible except for his disability. There is no provision for maternity benefits, and no benefit is paid in these cases except after termination of pregnancy and then only after 2 weeks following return to covered employment.

Provision is made to prevent duplication of benefits. Persons are disqualified if they are receiving Social Security old-age benefits or an annuity or pension provided by the employer or coming from a fund to which the employer has contributed, if the amount of the benefit equals or exceeds the disability benefit. Disqualification similarly attaches to the receipt of a permanent disability benefit under any law except a veterans' program, or from any employer. The same holds true for unemployment insurance benefits under any law, and for workmen's compensation or employers' liability benefits for permanent partial disability before this law became effective. However, if a claim for workmen's compensation benefits is challenged on the ground that the disability was not covered by the state law, disability benefits are paid and the amount may be recovered later if the workmen's compensation benefits are awarded.

Beneficiaries are required to submit to examination by a physician at the employer's or carrier's request, but not more frequently than once each week and without cost to themselves. In contested cases, the chairman of the Board may direct examination by a physician he names, and he may do this for any unemployed beneficiary.

Unemployed Workers. Special provision is made for workers who become disabled while unemployed. Unemployed workers who are entitled to unemployment insurance benefits within 26 weeks

immediately following termination of their employment, are eligible for disability benefits during that 26-week period, for each week they would have received unemployment insurance benefits had they not been disabled. The weekly benefit amount, maximum and minimum, and the duration applicable to employed workers are applicable to them.

Unemployed workers who are not eligible for unemployment insurance benefits and who were paid by covered employers at least \$13 a week for at least 20 calendar weeks during the 30 calendar weeks immediately preceding the last day of employment for a covered employer, may be eligible. They are eligible if, during the 26-week period of unemployment following the last day of employment for a covered employer, they are not eligible for unemployment insurance because they lack the necessary qualifying wages. They are eligible during this 26-week period provided they had "continued attachment" to the labor market, i.e., were not "in and out" employees. These employees may be required to file proof of disability, wages, employment, and such other proof as might be required, and they may also be required to file reports.

Insurance and Contributions. The New York Act imposes upon employers the liability to pay benefits. Beyond that it requires that the liability be insured. There is a state fund, the same one that sells workmen's compensation insurance, with which the employer may insure his liability. He may insure with a private commercial carrier if he prefers. Or he may be a self-insurer, if he can offer adequate evidence of ability to carry the liability. Private plans differing from the pattern set by the law may thus be established by employers, provided the benefits are at least as favorable as those established by the law and eligibility requirements are no more restrictive.

There is a special state fund from which benefits are paid to unemployed workers who qualify and from which benefits are paid also to qualified employed workers whose employer defaults on his liability. This fund was established by a special tax, levied for 6 months, of 0.2 of 1 percent of wages, but not to exceed 12 cents a week per worker, and one-half of this was assessed against employees. If on April 1 the net assets in the fund are \$1 million or more below \$12 million, or less than twice the benefits paid to unemployed workers in the preceding fiscal year, whichever is greater, the insurance carriers, including the state fund, are assessed enough in proportion to covered wages to bring the amount to \$12 million

or twice the benefits paid, whichever is greater. But this assessment is not levied on the pay rolls covered by private plans that pay benefits to unemployed workers. Should the amount in the special fund fall below \$3 million and disability claims indicate that more money will be needed before the next assessment date, which is April 1, the Board may assess and collect immediately. The state does not assume any liability for paying these benefits from its own funds.

Regular contributions from employed workers are set at 0.5 of 1 percent of wages, but are not to exceed 30 cents per week for any one employee. This contribution may be collected by the employer whether he insures with the state fund or a commercial carrier, or carries his own risk. The employer's regular contribution is the difference between the cost of the benefits to him and the amount collected from his employees.

The expense of administering the program for both employed and unemployed workers, not including what it costs the state to act as a carrier, is assessed against the carriers in proportion to covered pay roll, and the law sets no limit on the amount of those expenditures. The state, as a carrier, bears its share of this expense. Private carriers bear whatever administrative expenses they may incur.

Operations. As of July 1, 1952, a total of 4.6 million workers were covered by the Act, and their total pay roll for 1952 was estimated at \$11.8 billion. No data are available on the amount of contributions; but for 1952 a total of \$79.4 million was paid in benefits, including about \$6.1 million in hospital, surgical, and medical care benefits paid in lieu of cash. The average weekly number of beneficiaries was 44,100 and the average weekly benefit for a full week of disability was \$31.79, which is more than the maximum required by the law. The cost of administering the system for the fiscal year ending March 31, 1952, was \$1,170,000.

SOME OBSERVATIONS

It seems reasonable to believe that compulsory cash sickness benefit plans will in time spread over the entire country. Huge, and in some instances excessive, sums have been accumulated in unemployment compensation reserve funds, and employers' taxes have been greatly reduced. The movement for national compulsory medical care insurance seems to have lost its momentum, and the time is opportune for applying pressure elsewhere. Cash sickness benefit plans can be worked out separately in each state on a piecemeal

basis, although appropriate Federal legislation would speed the movement. Proposals have already been introduced in many state legislatures, and the pressure for their enactment will steadily grow heavier.

American experience with compulsory cash sickness benefit plans is exceedingly limited, and will remain so until more laws are enacted and put into operation. The many practical problems that exist and others that arise will have to be solved in the light of American conditions and experience. Since we are uncertain as to what types of plans are preferred, it is likely that considerable experimentation will take place. And it is really desirable that this be done.¹⁰

One important problem involves the relationship of benefits to current wages at the time of disability, a problem common to all forms of social insurance. A high ratio of benefits to wages will result in a higher claim rate and in more malingering, and it will affect the reserve fund adversely. The fact that sickness benefits are tax-exempt, and the fact that some expenditures normally incurred in connection with earning an income are not made during sickness, should be considered in establishing the benefit level. It is true that any reasonable relationship so established might be disrupted by changing wage and employment levels, since benefits are generally computed on the basis of earnings from some distant past period. But an administratively determined level, such as was used in many state minimum wage laws, appears to be out of the question. Employers would object to necessary tax increases and workers would object to benefit decreases.

Many believe that compulsory cash benefits should be at the minimum of subsistence level and that supplementary benefits should, wherever possible, be provided on a voluntary basis. It is possible that the voluntary plan system being used by California and New Jersey will solve the problem of providing more than a minimum of subsistence benefits by law for many workers. At least it can be said to provide the opportunity. Allowing voluntary plans, subject to appropriate safeguards, has other possible advantages. But it is not unlikely that the device will be used in many states merely as a method of relating individual employers' contributions to the cost of benefits to their own employees—a kind of "merit rating"—

¹⁰ R. A. Hohaus, *Compulsory Cash Sickness Benefit Plans*, Metropolitan Life Insurance Co., 1946.

except perhaps where strong unions take a part of their wage increases in the form of higher cash disability benefits. Yet there should be a state operated system, if for no other reason than to provide for those who cannot participate in voluntary plans or who prefer not to do so.

The payment of cash sickness benefits to persons who are no longer in the labor force can be justified, if at all, only in the absence of a system of medical care insurance. People who are too old to work should not be eligible for cash disability benefits. Nor is there any compelling reason for giving a "free ride" on the sickness benefit bus to people temporarily attached to the labor force and who thereafter leave the force for good. It is unwise to lay on one system a burden that more properly belongs somewhere else. It is not likely, however, that qualifying conditions for sickness benefits will be more rigorous than for unemployment compensation.

By the same token, the administrative machinery of some other system should not be used for cash sickness plans without making necessary modifications. Claims machinery for unemployment and sickness certainly should not be identical. Sickness claims would seem to warrant considerably more personal attention by highly trained specialists than do unemployment claims. Availability for work cannot be easily tested by requiring appearance at an employment office and by the offer of a job, but must be tested by medically trained personnel. Yet it does not follow that an entirely separate administrative system is necessary. It is possible to make modifications in the unemployment compensation administrative machinery which will enable much of it to be used successfully for the cash sickness benefit system. This should not blind legislators to the fact that paying sickness benefits involves a lot of work and requires considerable additional personnel. Effective administration will more than pay for itself.

Three different methods, or sources, of financing cash sickness benefits are now in use. In Rhode Island and California benefits are paid altogether out of funds contributed by employees, while in the railroad system the benefits are paid altogether by the employers. In New Jersey and New York, both employers and employees contribute. Should Congress permit the use of some unemployment reserves other than those contributed by employees to pay cash sickness benefits, joint financing, which is probably the best method, would probably become the rule. For it is not likely that most

present state unemployment compensation rate structures can also support cash sickness benefit payments indefinitely. And as reserves dwindled, employee contributions might well be considered necessary. Congress did add a cash sickness benefit plan to the railroad unemployment insurance system, which is altogether financed by employers. But the railroad contribution rate at that time was fixed at 3 percent, and although the rate may now be reduced, yet there are limits below which it is not permitted to fall.

There is considerable opposition to the expansion of the cash disability benefit movement, but it is certain that the movement will continue to grow. One business executive, in answer to the question whether employers should fight the movement, replied: "It appears to be the wisest course for business to cooperate fully with the agencies that are trying to develop these programs. If industry will apply its ability to this problem, something much better can develop from it."¹¹ In other words, some industrial leaders appear to be convinced that the movement will succeed and that by assisting in its development, the end result will be sounder, at least from their point of view.

COMMERCIAL GROUP POLICIES

There are group accident and health policies, frequently written in combination with group life insurance, but now also commonly as separate policies, which pay cash sickness and accident disability benefits. The number of persons covered by such policies was approximately 2 million in 1930, had increased to 2.5 million in 1935, reached 6 million in 1945 and was approximately 10 million by the end of 1953. Commercial group policies are written for a period of one year, with necessary premium adjustments made for the following year.

As with other types of group insurance, a minimum number is required before a master policy is issued, usually 25, and where the employer contributes a part of the premium, as is done in approximately half of the cases, then 75 percent of the group must join. Only full-time employees, usually only those under 70 years of age, employed for at least three months are insured, but they are not required to pass a physical examination when the group is originally

¹¹ H. G. Waltner, administrative assistant, Insurance and Social Security Department, Standard Oil Company of New Jersey, in *What's New in Insurance Legislation*, American Management Association, 1947, p. 15.

enrolled. Provision is made for admitting subsequently employed individuals, after a short probationary period of employment, usually three months. Coverage is canceled when employment is terminated, and usually the terminated employee is not permitted to convert to an individual policy.

The amount of disability benefit any employee may receive is generally limited to two-thirds of his wages. The benefit rate may be the same for all employees, or it may be made to vary with wages. Disability covered by workmen's compensation is not included.

Benefit payments begin after a waiting period, varying in different policies from three to seven, sometimes 14 days, and are usually limited to a maximum of 13 weeks in any 12-month period for any one disability, and never for more than 52 weeks, with the special proviso that for persons over 60 years of age the specified maximum duration of benefits is for all disability during the year and not merely for any one disability. Benefits are paid in pregnancy cases, but usually for not more than six weeks.

For a weekly benefit of \$10 payable in case of either accident or sickness, after a three-day waiting period for sickness and no waiting period for accidents, and for a maximum duration of 13 weeks per disability, and where females constitute less than 11 percent of the group, the basic monthly premium, in industries not especially hazardous, is 80 cents. An additional 13 weeks can be had for a total premium of \$1.01, and for 52 weeks of benefit the total premium is \$1.14. Increasing the waiting period in sickness cases to seven days but with no waiting period in accident cases, gives the following basic rates: 13 weeks' duration, 66 cents; 26 weeks', 86 cents; 52 weeks', 98 cents. Rates for sickness coverage only are but a few cents less than for both sickness and accident. The rates for women, Mexicans, Chinese, and Japanese are double those for white men in standard nonhazardous industries, and Negro women are counted once as women and once as Negroes. Rates for mixed groups are determined by the particular composition of the group. It is not unusual for companies to declare dividends or to make rate adjustments on group policies at the end of the year, returning excess premiums charged.

Commercial group annuity policies may also provide, for an extra premium, limited benefits in cases of total permanent disability. They provide that a totally permanently disabled employee may elect to receive a paid-up deferred annuity or to cancel his annuity and take

in cash a share of the policy's surrender value proportionate to his contribution. When the worker elects to take cash, he is usually paid off in twelve monthly installments.

The number covered by individual accident and health policies is greater than the number covered by group policies, and amounted to some 9 million at the end of 1946. The total of 16 million with group and individual coverage does not represent that many different individuals, since approximately 56 percent of those having health policies also have accident policies. The summary data in Table 73 indicate the level reached by commercial coverage and the growth from 1945 to 1946.

TABLE 73. Summary of Health and Accident Insurance of United States Residents, 1945 and 1946 ¹²

I. Individual Health and Accident Policies

Kind of Policy	Policies in Force (000 Omitted)		Weekly Indemnity in Force (000 Omitted)		Weekly Indemnity Claims (000 Omitted)	
	1946	1945	1946	1945	1946	1945
Accident only ^a	2,907	2,422	\$ 79,756	\$ 64,275	174	146
Health only ^a	147	128	4,178	3,746	17	14
Accident and health combined ^a	7,837	6,091	108,890	85,580	2,037	2,411
Total	10,891	8,641	\$192,824	\$153,601	2,228	2,571
Specified risk ^b	2,655	3,428	.. ..	.. ..	.. ..	.. ..
All other	2,269	1,939	.. ..	.. ..	.. ..	.. ..

II. Group Accident and Health Policies Providing Weekly Benefits

	1946	1945
Weekly indemnity group contracts in force	\$ 26,820	\$ 23,059
Weekly indemnity certificates in force	7,008,000	5,928,000
Amount of weekly indemnity in force	127,200,000	100,830,000
Weekly indemnity claims paid ^c	1,100,000	1,274,000

^a Policies are not included which provide only principal sum, hospital expense, medical expense, or surgical expense benefits, or policies limiting coverage to specified risks.

^b Includes all limited policies, but not those which provide only hospital expense, medical expense, or surgical benefits.

^c Includes estimate of the number of claims on which first payment was made in 1945 or 1946.

¹² A. L. Kirkpatrick, *American Economic Security*, January 1948, p. 25.

EMPLOYEE MUTUAL BENEFIT ASSOCIATIONS

Employee mutual benefit associations have existed for many years in this country.¹³ Their principal function is to pay cash disability and funeral benefits, although some provide hospital and medical service benefits as well. The earlier ones were organized by workers themselves, and frequently independently of their particular workshop, but later employers sponsored such schemes in their own establishments as a part of their personnel work.

There are approximately 600 employee benefit associations, with some 1.5 million members, widely distributed geographically and industrially. They are declining in importance, largely because the insurance functions they perform are more effectively performed by other agencies, such as commercial companies with their group policies. The development of governmental cash disability benefit laws would practically abolish the movement.

Membership is nearly always voluntary, but associations generally have highly restrictive membership requirements. Employees over 50 or 60 are usually excluded because of their higher morbidity rates; and a few associations also exclude women and Negroes for the same reason. Persons suffering from chronic diseases are generally admitted if they waive benefits for those diseases. In two-thirds of the associations no physical examination is required. In about one-half there is no probationary membership requirement before eligibility to benefits, the others requiring usually one month, which is less restrictive than most group insurance plans. Furthermore, membership may frequently be retained for substantial periods after employment is terminated. Disabilities which are covered by workmen's compensation laws may or may not be compensated. There are a few other exclusions: disability resulting from intemperance, immoral conduct, fighting, and in those associations admitting women, pregnancy and childbirth and diseases peculiar to women. There is a waiting period, usually of 7 days, in any disability before benefits are payable, but in many instances benefits are retroactive where the disability continues beyond a specified period.

¹³ See H. Ladd Plumley, *Budgeting the Costs of Illness*, National Industrial Conference Board, 1947, chap. ii; Elizabeth L. Otey, *Cash Benefits under Voluntary Disability Insurance in the United States*, Bureau of Research and Statistics Report No. 6, Social Security Board, 1941, chap. v

Cash benefits, usually uniform for all members, are set at a fixed amount, which is usually \$10 per week, but in some associations the benefit is stated as a percentage of wages, usually one-half or two-thirds. The number of weekly benefits payable varies from five to 52, the most common being 10, 13, and 26, found in about half of the plans. In a few plans there is a specified maximum sum payable. In a few, duration is made to vary with the state of the treasury, sex, length of membership, or length of service. Permanent disability is not compensated beyond the limited duration provided for temporary disability. There is usually a small funeral benefit. Claims are investigated by a committee of members, but certification for benefits is by a physician or nurse.

These benefits are financed by regular dues, usually uniform for all, but sometimes varying with wages and sometimes with sex and age. The dues are usually deducted by employers, although a few societies have collectors. The most common amount charged is 50 cents per month. About half of the associations receive some support from their employers, and in such associations the employers participate in the management in proportion to their support.

The ease with which rates and benefits may be changed, the extremely low cost of administration, and the small amount of malingering that results because of visiting committees and the general attitude of members have kept these associations solvent despite the fact that most of them are not organized on an actuarial basis.

PART SIX

CONCLUSION

CHAPTER TWENTY-THREE

SOME GENERAL OBSERVATIONS

WHAT has been set down in the preceding chapters constitutes an outline of American social insurance, with sufficient details to add a bit of body. It is the outline of a relatively young and a rapidly changing movement. On the whole, what we have is distinctive and impressive. The United States has taken its place alongside other leading industrial nations in the social insurance movement.

How did social insurance come to pass? Why did it not come sooner? What are the major factors accounting for its origin and development? What are the major "defects" of the American system? What major changes are being proposed? What are some of the obstacles to improvement? Many and varied answers have been given to these and other questions concerning social insurance. It will be worth while to spend a little time with them.

FACTORS IN THE DEVELOPMENT OF SOCIAL INSURANCE¹

Students of the history of social movements approach their task humbly and with many misgivings, for the number, variety, and interplay of forces involved have woven amazingly complex patterns and have left discouragingly few traces of themselves. Elizabeth Brandeis, an able and experienced researcher, has stated the problem succinctly, as follows:

Material on how specific laws came to be passed is fragmentary in the extreme. The official records in most States reveal nothing—there are no stenographic reports of legislative hearings or legislative debate. Even if

¹ The following analysis of factors in the development of social insurance is taken largely from the author's chapter, "Minimum Income Insurance," in Seba Eldridge and associates, *Development of Collective Enterprise*, University of Kansas Press, 1943, chap. 20.

such records were available, they would not reveal completely the interplay of forces which actually put the particular measure on the statute book. Even the participants in a campaign to secure a given piece of legislation can only guess at the real explanation for their success or failure.²

Yet it may be worth while to summarize briefly, even though imperfectly, what seem to be the major factors leading to the establishment of social insurance measures.

Evils of Industrialization. There can be no doubt that the evils against which social insurance as we know it is directed are primarily products of the modern capitalistic economy, although some of the evils exist elsewhere and noncapitalistic societies have their own systems of social insurance. By 1850, European industrialized capitalism produced annually a "destitution problem of serious proportions."³ The extent of that problem has probably been considerably exaggerated, but it was serious. More important was the fact that the factory system and urbanization, by concentrating the unfortunates, and perhaps adding to their numbers and distress, made their plight conspicuous and greatly reduced the possibilities of relief through individual and familial charity. The public poor relief necessary became sufficiently expensive to alarm taxpayers and demoralizing enough to alarm statesmen.

Politico-Economic Philosophy. In England, destitution and poor relief were important problems. Yet England did not rush into a system of social insurance. Something more than industrialization and its attendant suffering was essential. In England at that time, as in the United States until very recently, the doctrine of individualism was rampant. Adam Smith and the classical English economists made of *laissez faire* a cardinal philosophical and economic doctrine, but they succeeded in doing so only because *laissez faire* did considerably more good than harm at that time, even for the workers. As late as 1892, one good man could argue that "the utmost duty that lies upon the state . . . is to prevent people from dying of starvation, when they are ill or too old to work, and this it already

² D. D. Lescossier and Elizabeth Brandeis, *Working Conditions and Labor Legislation*, vol. iii of Commons and associates, *History of Labor in the United States*, The Macmillan Company, 1935, p. 400.

³ Barbara N. Armstrong, *Insuring the Essentials*, The Macmillan Company, 1932, p. 9.

does through the operation of the Poor Law.”⁴ This man could consider the trade unionists’ demand for the abolition of the common-law fellow servant rule as “preposterous.”

It was in Germany that a broad national program of sickness and industrial accident insurance was first launched, in the years 1883 and 1884. The German economy developed rapidly after 1850, and especially after 1870. But it would be an exaggeration to say that the resulting conditions of the workers were the decisive factor, particularly in view of the fact that such conditions developed earlier and were worse in England.

In Germany, the leading philosophers and economists had not fallen under the influence of the doctrine of *laissez faire*; on the contrary, state interference in the economy was an accepted policy.⁵ This fact, however it may in turn be explained, played a significant role in the development of German social insurance. But more important perhaps than the acceptance of the doctrine of state interference was the existence of a growing Socialist movement. Socialism itself can be explained simply, indeed too simply, in terms of economics. Even more important than the Socialist movement was Bismarck, who wanted to win the workers away from socialism and to create a state which would be something of a mean between bourgeois democracy and feudal absolutism, and who, although not above all things a great humanitarian, wanted also to establish a more humane social and economic order.⁶ An unusual “conjuncture” of economics, power politics, paternalism, socialism, and personalities accounts for German leadership in national social insurance, but how the conjuncture was effected and the relative importance of each factor involved cannot possibly be evaluated.

Personal Leadership. The next great step forward was taken by England in 1911 when the first nation-wide compulsory unemployment insurance law was enacted. How that happened is none too clear. Abraham Epstein’s conclusion that protests by workers against their conditions account to a considerable extent

⁴ George Brooks, *Industry and Property*, Suffolk, published by the author himself, 1892, vol i, p 251.

⁵ I. M. Rubinow, *Social Insurance*, Henry Holt & Company, Inc., 1913, p. 15. Melchoir Palyi, “The Introduction of Adam Smith on the Continent,” in *Adam Smith, 1776–1926*, University of Chicago Press, 1928, chap. vii.

⁶ Hans Rothfels, “Bismarck’s Social Policy and the Problem of State Socialism in Germany, Part II,” *Sociological Review*, vol. xxx, 1938, pp. 288–302.

for the English movement is not convincing.⁷ It may never be known why compulsory unemployment insurance came first in England. A few powerful personalities there were, but time, place, ideology, politics, and economics were all, if not against them, then at least not with them. Here, certainly, there was no conjuncture of circumstances such as seems to explain the first great German step.

The Royal Commission on the Poor Laws and Relief of Distress (1905-1909), both majority and minority groups, was opposed to a compulsory scheme.⁸ So was the Charity Organization Society, and so were the trade unions. The Webbs were opposed because they feared that the union movement would be injured. But at the instance of Winston Churchill, Hubert Llewellyn Smith and William Beveridge developed a compulsory, but restricted, plan; and this "almost unsolicited and spontaneous" and almost universally opposed venture on the part of Winston Churchill was put through Parliament by Lloyd-George. And the act was not popular.⁹

Before President Roosevelt's "New Deal," only workmen's compensation had been well developed in the United States. One reason commonly given in explanation of our laggardness was the persistence of the 18th century doctrine of individualism, so well expressed in Jefferson's dictum that "that government is best which governs least." But in Germany, where the doctrine was never generally accepted, the national system was not begun until 1883, and in England, where the doctrine was accepted, we find workmen's compensation as early as 1897 and the first development of national compulsory unemployment insurance and a comprehensive compulsory health insurance system in 1911. Even a cursory examination of countries and dates shows that social insurance readily found its way into countries where the doctrine of individualism was strong and lagged in many countries where it was weak.

Organized Labor. Two other reasons generally given for our laggardness were the political weakness of labor and the opposition of unionism. These are really inconsistent with each other, since the political strength of labor is a function of the extent of its organiza-

⁷ *Insecurity, A Challenge to America*, Harrison Smith & Robert Haas, 1936, pp. 24-25.

⁸ Mary B. Gilson, *Unemployment Insurance in Great Britain*, Industrial Relations Counselors, 1931, pp. 40-41, R. C. Davidson, *The Unemployed*, Longmans, Green & Company, Inc., 1929, chap. iii.

⁹ R. C. Davidson, *op. cit.*, pp. 74-75, 79.

tion. But the relationship between the economic and political strength of labor and the initiation of social insurance systems has not been great in any country. In Bismarck's Germany, unions were not powerful, although their alliance with the Socialists was of some consequence; English unions in 1911 were powerful and they were opposed to compulsory unemployment insurance; and American unions in 1935 were beneficiaries of rather than contributors to the strength of the New Deal.

Written Constitutions. Another reason advanced was the existence of written constitutions. But this also is not convincing. Workmen's compensation was possible and was achieved. Comprehensive plans for public employees were possible, but were not and have not yet been developed. The first Federal railroad retirement act, which might have been attempted fifty years earlier but was not, was declared unconstitutional, yet a retirement system for railroad employees was nevertheless achieved, and without sanction of the courts. Wisconsin enacted an unemployment compensation law.

Timidity. Professor Eveline Burns argues that often social reformers aim too low, that they "inch along" with meager public support when greater daring would dramatize the possibilities and bring more vigorous and widespread public support.¹⁰ The experience of Winston Churchill and Lloyd-George in securing the enactment of unemployment and health insurance lends some support to that view, as does Bismarck's experience. But let it be noted that even they "inched along," and that vigorous public support was slow in coming, indeed came only after they had succeeded. Early bills presented to American legislatures would have established substantial programs of social insurance, but vigorous support was not forthcoming. It would seem idle to maintain that had the proposals been even more daring, public support for them would have been created or crystallized. American experience with the Lundeen unemployment benefits bill supports this view. Fortunately, more than vision and daring is necessary.

Laggard Public Opinion. The common thesis that a laggard public opinion was the chief cause of delayed provision for social insurance can hardly be accepted. Bismarck, Lloyd-George, and Franklin D. Roosevelt succeeded in making great strides without

¹⁰ *Towards Social Security*, McGraw-Hill Book Company, Inc., 1936, p. viii.

the support of an active favorable public opinion. Perhaps no crusade in the United States has had so much support as the Townsend \$200 a month old-age plan, but little good that public opinion did it.¹¹ The point is beautifully made by C. A. Kulp when he says: "There is no harder question, even for the veteran social reformer, than 'how did this law get itself passed, who were its supporters, why was it passed at this time and not sooner or later?'" One thing is certain: it was not the pressure of a widespread aroused public opinion. The public wakes up first to a new social insurance law when jobs are to be handed out, second and much less definitely and certainly when the new law begins to show its first flaws."¹²

Whatever may have been the reasons for our laggardness, the nation was suddenly catapulted into compulsory old-age and unemployment insurance and substantial assistance grants to needy persons by President Roosevelt and the "New Deal." A neat explanation of the forces and events leading to that move may be given. The depression convinced us of the need for action by government, gave us President Roosevelt, who in turn gave us a "New Deal," of which one aspect was social insurance. Neat, but not very illuminating. It would be better to say that there was a need for social insurance, that leaders conscious of that need existed, that political and economic conditions were favorable to legislation, that experience and study had provided the basic plans to be considered and enacted. Here, as in Bismarck's time, there was a conjuncture of economics, politics, "socialism," and personalities out of which emerged the Social Security act and other insurance legislation.¹³

There is a hypothesis that in a capitalistic democracy extensions of collective enterprise are effected mainly or primarily through the pressure of consumer and general public needs or interests, exer-

¹¹ The influence of such movements is discussed by Joseph Cohen in "Social Security and Social Movements," *Sociology and Social Research*, March-April, 1939, pp. 312-320.

¹² In *American Labor Legislation Review*, March 1938, p. 18.

¹³ Edwin E. Witte believes "that but for the efforts of Secretary Perkins and her assistants, and, above all, the insistence of President Roosevelt and the loyal support he received from the leaders of the congressional committees having this legislation in charge, the Social Security Act would not have become law even though in the final vote the measure passed both houses by large majorities. It is also my conviction that if this law had not been enacted at the time, no legislation on the subject could have been gotten through Congress in the next five or six years." *Yale Law Journal*, December 1945, p. 31.

cised directly by the consumers themselves or indirectly on their behalf by socially-minded groups or individuals.¹⁴

It may be asserted dogmatically and confidently that social insurance was not achieved primarily through the pressure of those whom it is intended to benefit. The weak pressure exerted by the beneficiaries has as often as not been against its adoption. Liberalization of the benefits of such legislation has, however, frequently been the result of pressure from those covered. Nor is there much reason to accept the opposite extreme view that "the social insurances have been inaugurated largely as a political strategem."¹⁵ The fact that such legislation is necessarily sponsored by politicians who are concerned with their own fortunes has led some unwary researchers astray. There was considerably more than political stratagems in the social insurance policies of Bismarck and Roosevelt, of Winston Churchill and Lloyd-George.

Social insurance movements arose mainly out of general public needs, as those needs were conceived by social reformers. It would be difficult to conceive of such movements arising out of any other circumstances. There may be, and generally are, differences of opinion as to what public needs are and how they can best be satisfied. But no one will seriously contend that in general those indomitable and unselfish men and women in private life and public service leading the fight for social insurance were dominated by any other desire than to improve the lot of wage earners. The Marxian doctrine that collectivism results from action by wage earners in class conflict finds no support whatsoever in the history of social insurance movements.

There were minor interests involved, but not many. Many employers favored workmen's compensation because they thought it might be cheaper than employers' liability and also because it would improve personnel relations. Railway unions favored a Federal retirement act because private pensions were proving so costly and were being menaced, and also because it would relieve unemployment among their younger members by stimulating retirements. Some insurance company executives were convinced that the Federal Old-Age and Survivors Insurance system would lead

¹⁴ Seba Eldridge and associates, *Development of Collective Enterprise*, chap. 1.

¹⁵ Twentieth Century Fund, Inc., *More Leisure for Old Age*, 1937, p. 13.

to more commercial annuities. The National Retail Dry Goods Association favored the Social Security Act on the theory that consumers' purchasing power would be better maintained by it. Hospital management favored group hospitalization plans largely because they promised to increase revenues. Other examples could be given, but these will suffice.

SOME "DEFECTS"

As in most other countries, American social insurance has come in stages. Indeed, one could say that we have moved mostly in jerks, or lunges. Workmen's compensation came with surprising suddenness within a few years beginning about 1911; Federal Old-Age and Survivors Insurance and unemployment compensation came almost "out of the blue," or to be more accurate out of the inky blackness of the Great Depression. Voluntary hospital insurance developed a tremendous momentum within the past few years; and voluntary medical care prepayment plans have had a similar, but a later and considerably less spectacular, development. It is true that these movements all had "beginnings" and that changes, in some cases fundamental ones, were made after the movements were well launched. But each one "blossomed" in a relatively short period of time, except medical care insurance, which is still in the budding stage. A system so developed could hardly help having many imperfections.

Diversity. One outstanding characteristic of American social insurance is the great diversity found as between states. The extremes are sometimes striking. This result is the only one to be expected where some fifty different political units legislate largely independently on the same general subject. Federal requirements establish only minimum amounts of uniformity in some types of plans, and none at all in others. There is indeed even much diversity as between different Federal systems covering the same hazard, notably in the many separate Federal retirement systems, each of which seems to be a law unto itself. The differences do not, as some seem to believe, represent the results of a race between states to get competitive advantages over neighboring states. They are rather the results of differences in economic structure, wealth, and social attitudes. The differences persist, and there is no good reason to suppose that they

will in the near future, or ever for that matter, diminish appreciably in degree.

To be sure, much can be said in favor of diversity among plans. Experimentation along many lines is desirable, even necessary, since generally acceptable basic concepts have not yet been developed in some fields of social insurance.¹⁶ Thinking on the subject is in a state of flux, and diversity should provide some helpful data for formulating general conclusions. It is not reasonable to believe, however, that those most concerned with social insurance, and especially those who are most interested in having diversity, will carefully weigh the experience under different systems with a view to improving their own, at least not to any extent. For more than one-third of a century now we have had experience under many different workmen's compensation plans, and we have not achieved uniformity, not even a desire for uniformity. Indeed, there is relatively little interest in workmen's compensation, even among students of social insurance.

The varied and dynamic nature of our country would seem to justify considerable diversity. Different sections of the United States are in many respects almost like different countries, the Pacific and South Atlantic coast states, for example. The mere fact that states are included within the confines of a single overall federated political unit does not of itself dictate uniformity in social insurance programs, any more than it dictates uniformity in social customs, educational programs, or accounting procedure. The country as a whole is dynamic, but not all sections change, or change at the same rate or in the same direction.

Diversity in the United States is inevitably involved with the question of state sovereignty. Uniformity, even a high degree of it, can be achieved in effect only if states yield more power or influence

¹⁶ The situation with respect to unemployment compensation has been summed up as follows: "There never has been agreement as to the purpose of unemployment compensation or its basic principles. Differences of opinion among the champions of the institution are so extreme as to disrupt lifelong friendships and to provoke more heat than light in discussions. Unemployment compensation differs so much from state to state that there is a large element of truth in the claim that there is no such thing as an American unemployment compensation system. It is not now and never has been entirely satisfactory to any of the specialists in this field nor to any element in our complex society." Edwin E. Witte, "Development of Unemployment Compensation," *Yale Law Journal*, December 1945, p. 21.

to the Federal government. Nothing in our history lends much support to the notion that states will voluntarily adopt uniform legislation or procedure to any appreciable extent. But the question of the distribution of sovereign power as between Federal and state governments is fundamental to Americans, more fundamental than that of uniformity of social insurance programs. American states appear to be more interested in exercising their sovereign powers than in achieving uniformity. On its lowest level, the conflict involves the control of jobs. "Job consciousness" is a phenomenon not found exclusively among trade unionists.

It should be added that social insurance and public relief are not well coördinated, either on the national or local levels. Some serious complications result, especially since in numerous instances relief grants are more ample than social insurance payments, and often social insurance payments must be supplemented by relief grants.

The marked mobility of the American labor force and diversity in social insurance programs have led to much dissatisfaction, some injustice, many problems, and extra costs. Uniformity would eliminate or reduce some of the dissatisfaction, injustice, and problems resulting from diversity. But there are some problems and injustices that it would not eliminate or reduce. Furthermore, and fully as important, uniformity would in turn introduce many problems and injustices on its own account.

Coverage. A "spotty" coverage has been one of the inevitable results of our political structure and of the manner in which our social insurance has developed. Not all of the major hazards are covered. Prepaid medical care and cash benefits for nonoccupational disability are the two major gaps now existing in the coverage of hazards, although some progress in filling them is being made. Here the movement is still almost altogether voluntary and it may well remain so for some time to come, despite the strenuous efforts that have been made to enact compulsory legislation. A few compulsory cash disability programs have been initiated, and there seems to be little likelihood that they will spread rapidly. As yet there is practically no invalidity insurance outside workmen's compensation programs, and not enough of it there.

It is characteristic of American social insurance that numerous subdivisions of the major types of hazards which are covered are excluded from that coverage. Thus not all occupational injuries are covered by workmen's compensation laws. Occupational diseases

are not yet included in all compensation laws, and in some of the laws they are not all included. Existing hospital care plans do not cover all admissions, although the exclusions of types are not especially important. It is not so with nonprofit medical care plans, where more appears to be excluded than is included. Our Federal Old-Age and Survivors Insurance system has gaps in the coverage of insured, dependents, and survivors. Unemployment compensation, especially as the laws are interpreted in some jurisdictions, has its gaps.

Furthermore, most of the hazards included are not completely covered. There are limits, for example, on the amount of medical care and the duration of cash disability benefits payable under some workmen's compensation laws for covered injuries. Hospital care plans provide sufficient coverage for included cases to care for nearly all required hospitalization, but medical care plans have definite and rather narrow limits. And the same is true of unemployment compensation, which is in fact specifically designed to cover only short periods of unemployment.

Occupational exclusions still appreciably limit the scope of our social insurance programs. Agricultural and domestic service and self-employment are now compulsorily included in the Federal Old-Age and Survivors Insurance system. But these groups are for the most part still excluded from workmen's compensation, unemployment insurance, and cash disability benefit programs; and the progress made to date in extending voluntary nonprofit hospital and medical care programs to agricultural and household workers has been exceedingly slow.

Numerical limitations are also characteristic of American social insurance programs, although to a lesser degree than formerly. Many, if not most, workmen's and unemployment compensation laws have numerical limitations. That is to say, employers with fewer than specified numbers of workers are not compulsorily covered. Here again, administrative difficulty explains the original limitations, but timidity and lethargy largely explain their continuance.

Income limitations are less common, and to date are found mostly in voluntary medical care plans, where their effect is either to exclude altogether some persons from participating or, more commonly, to limit the benefits which are available to them. The traditional privilege enjoyed by doctors and hospitals of charging their clients pretty much what the traffic will bear accounts for

these limitations. Had the Taft substitute for the Wagner-Murray-Dingell bill, described in Chapter 18, been enacted into law, income limitations would have become applicable in medical and dental care programs established by states.

This analysis of the gaps in coverage is not intended as an argument for the inclusion of all persons and all hazards in social insurance systems. It is rather a simple summary of what we do not have. Whether we want more or less, and the manner in which we want to supply more, or something different, is a separate question, which will be discussed briefly below.

Benefits. The benefit pattern of American social insurance is something like a crazy quilt full of holes and rather skimpy in both length and breadth. Here again is an inevitable result of the Federal-State structure of American government, of the great diversity of interest and economies among the states, and of the piecemeal manner in which the pattern developed.

As they do in all systems everywhere, American benefit rates generally fall far short of meeting the full needs of those who receive them, although in isolated instances they amount to more than the recipients normally receive in full-time employment. It is not intended that the amounts received in social insurance benefits be adequate to meet all needs, not even to meet all basic minimum needs, however they may be defined. Benefits are geared more closely to earnings than to needs, although both factors are considered. Social insurance benefits are intended to be supplementary to other income. Yet it must be admitted that they do not even adequately supplement such other income as recipients have, especially among the lowest-income groups. However, nowhere have the lowest-income groups received insurance or relief payments adequate to meet their full needs, and usually not even enough to meet their basic minimum needs.

Increases in benefit payments have been made from time to time, but nearly always it has been a race between benefits and prices, with prices having a substantial head start and, at least since 1945 in this country, winning by several lengths. When prices decline, benefits automatically become less inadequate, but since 1929 that has happened infrequently and has not lasted for long. American social insurance is for the most part very young. Yet our experience with workmen's compensation, which is not so young, suggests that a few more decades will not result in adequacy of benefit amounts.

The period of time during which benefits are paid generally does not coincide with the period of time the losses insured against are experienced. Old-age and some workmen's compensation benefits are exceptions to this generalization, as are, of course, all individual cases where the duration of the loss is less than the maximum duration of benefits allowed by the law or plan. Maximum payments allowed, expressed in terms of time or amount or both, are common, and even necessary in American systems. The result is that in many cases prolonged disability or dependency or loss is not compensated. This is obviously true of nearly all voluntary medical care insurance. Our unemployment compensation systems are all deliberately restricted to short-term unemployment, as are most workmen's compensation systems, although to a much lesser degree. In other words, most of our social insurance plans provide benefits only for limited periods of time.

Social insurance is sometimes spoken of as minimum income insurance. In the early days of the movements, the principal objective appeared to be coverage of the lowest-income groups, of those who depended upon their weekly pay checks for current subsistence. Plans were therefore designed to make up in part for small losses. That objective remains, even though coverage extends to medium- and higher-income groups, where the bulk of those covered are found. The "waiting" period in unemployment compensation acts has been reduced to one week and cash disability benefits are payable after short waiting periods. Most compulsory health insurance proposals would provide medical care for any illness or disability, however insignificant it might be. The American movements have in this respect been greatly influenced by foreign models. As a result, much money is paid out in small sums to compensate in part what amounts to relatively small and insignificant burdens which could be borne by most of those upon whom they fall.

It is inevitable in any system of social insurance that benefit rates will be low and the period of time for which they are payable will be short if benefits are paid out for vast numbers of small losses, unless, of course, premium rates are correspondingly high. Furthermore, the problem of malingering is greater when small losses are compensated. And the costs of administration are necessarily higher. Malingering, high premium rates, and high administrative costs are, or will become, formidable problems in our social insurance systems.

Actuarial Aspects. It may be said that any system of insurance is actuarially sound when income from premiums and reserves, if reserves are accumulated, are adequate to meet current expenditures and accrued liabilities. Actuarial calculations must take into consideration many variables, the number and complexity depending upon the type of risk involved. In social insurance, the number and complexity of variables are so great that the systems are said to operate under "labyrinthian conditions."¹⁷ The extent of the hazard involved, future changes in the extent, future wage and price levels, population changes, age distributions, levels of employment, shifts between covered and noncovered employments, and other factors are involved. Actuarial science has a contribution to make to social insurance. It can provide "an approach to accuracy."¹⁸

One of the very worst characteristics of American social insurance, whether voluntary or compulsory, has been its actuarial aspect. Earlier voluntary nonprofit benefit plans have been the worst offenders against sound actuarial principles. Most of those plans were initiated by well-meaning individuals who were more interested in the benefits to be currently paid than in the difficult problems of rates and accrued liabilities. Members of groups, such as fraternal orders and trade unions, could, and in some instances did, vote to reduce rates and increase benefits at a time when the plan had an apparent balance on hand but was actually confronted with an actuarial deficit. Solidarity rather than actuarial science dictated action. It should be added, however, that adequate data were not generally available for useful actuarial studies. In social insurance, data are never adequate, but men must act nevertheless.

Contemporary voluntary nonprofit plans are doing much better in this respect. The managers of nonprofit hospital and medical care plans are keenly aware of the necessity for the application of actuarial principles to their operations and are striving to build their plans on sound foundations. Adequate data are not as yet available to lay a sound foundation in the fields of voluntary medical care and compulsory cash disability plans, but they are being accumulated and applied as rapidly as possible. Trade unions and fraternal societies have also generally learned some lessons, although current

¹⁷ Alfred Manes, *Insurance, Facts and Problems*, Harper & Brothers, 1938, p. 147.

¹⁸ Lewis Meriam, *Relief and Social Security*, The Brookings Institution, 1946, p. 720.

union health, welfare, and pension funds are still very inadequately financed. It is not intended to leave the impression that all voluntary plans are now actuarially solvent, but merely that there has been a vast improvement in this respect.

Government schemes have not been noted for strict adherence to actuarial principles. The very first municipal retirement system in the United States was established by New York City in 1857, but the first actuarially sound municipal retirement system was not established until 1920.

The soundness of existing compulsory governmental schemes is a much debated subject. It is generally conceded that the Federal Old-Age and Survivors Insurance system, although it is accumulating a reserve, is accruing more liabilities than present premium rates and reserves can redeem when they become payable. The Congress has consistently refused to levy the necessary rates, not because it is unaware of the actuarial principles involved, but because it objects to the accumulation of a large reserve. The actuarial soundness of the railroad retirement system is also questioned.

The basic financial problem involved in these two retirement systems is not really their actuarial soundness under present premium rates and benefit schedules. For the Federal government is morally obligated to make whatever payments are necessary to meet benefits promised under the Federal Old-Age and Survivors system, and furthermore it has power to raise the contribution rates. Nor is the railroad retirement system in danger of bankruptcy. For railroad managements and unions are ready either to make whatever rate and benefit adjustments are necessary to maintain solvency, or to bludgeon the difference out of the National Treasury. If government stands ready to meet operating deficits from general revenues, then governmental systems will be solvent as long as the government itself is able to pay. There is some question as to what extent government revenues should be used to subsidize systems of social insurance that do not have universal coverage, but no responsible person believes the government will repudiate its obligations.

Unemployment compensation is at the moment actuarially sound. Reserves are high, benefit rates and durations are moderate, benefit payments are low, and premium rates are low. The system has not yet experienced a severe test, except for a few short months in 1938. There is little reason to suppose that promised benefits cannot be paid, even in case of a fairly severe depression of several years

duration. A severe and prolonged depression would no doubt bring serious embarrassment and even difficulty to some states, but the movement as a whole can weather a fairly bad storm. It would not, to be sure, compensate very much depressional unemployment, and it is not intended to do so. Benefit payments would therefore be wholly inadequate to meet the needs of unemployed workers. But inadequacy of benefit payments should not be confused with actuarial unsoundness, although that confusion will no doubt become widespread. Provision is now made for enabling states to borrow when their reserves are low, and the fund from which such loans are made will without doubt be kept amply supplied by the Congress. Should the worst come, heavy deficits would be built up, presumably to be repaid in better times.

Pressure is being exerted to enact a national system of compulsory health insurance, one which would provide comprehensive, and expensive, medical, dental, hospital, nursing, and laboratory benefits. Estimated costs would be met by pay-roll taxes. It is not known what the costs would be, since adequate data with which to make reasonably reliable actuarial calculations are not available, and will not become available until such a system is in operation. But it is reasonably certain that benefit payments would expand more rapidly than income. In all probability, government contributions would be needed to bring income and expenditures into balance. Here again, the basic financial problem appears to be the ability and willingness of government to tax and contribute rather than the adequacy of proposed rates to meet the cost of proposed benefits.

Administration. The art of administration has until relatively recently lagged considerably in the United States.¹⁹ A new country, economically and politically, we have been too much absorbed in making and assimilating major conquests of our environment to be seriously concerned with administrative efficiency, especially on the part of governmental agencies. Pioneers in social legislation and humanitarian movements have succeeded in establishing programs, some private, others governmental, but in nearly every instance their main interest has been in the benefits to be provided, and they

¹⁹ One student has gone so far as to say that in the field of public administration there are not as yet adequate linguistic and conceptual tools for properly describing an administrative organization, let alone for determining what constitutes an effective one. Herbert A. Simon, *Administrative Behavior*, The Macmillan Company, 1947.

have tended to overlook the importance of requirements for administrative efficiency.

Early voluntary social insurance programs were blighted by woefully inadequate administration. Elected leaders of local unions and of local chapters of fraternal societies were not usually chosen because of demonstrated administrative ability, but rather for other reasons or qualities. Even when they served full time as local officers, their main interest was not the achievement of administrative efficiency in their social insurance programs, which were really of secondary importance. Mutual benefit societies may perhaps be considered as exceptions, for many of them were ably managed, largely no doubt because with them the benefit program was of primary importance.

Contemporary voluntary programs are for the most part being administered reasonably well. This is especially true of Blue Cross hospital organizations, where the administration is being put on a professional level. Trade unions are not adequately concerned with the efficient administration of their plans, but they are employing some competent administrative personnel. The marked growth in size of voluntary nonprofit plans has made it imperative that administration be improved, and has made it possible to pay for competent administrators and to utilize mechanical equipment.

American governmental agencies, at all levels, have in the past been notoriously weak with respect to administrative efficiency. Political acne, popularly and accurately known as the "spoils system," marred the adolescent complexion of American democracy under the party system, and that complexion has not yet completely cleared up. American antipathy to "bureaucracy" has perhaps more than any other single factor been responsible for the principle of rotation in office and has mitigated against the development of administrative efficiency.

There has been considerable improvement, on all levels of government. The Federal civil service, although it still labors under some serious difficulties, has unquestionably made for better administration. Politics has not been altogether eliminated, but the quality of the persons selected has been appreciably improved. Furthermore, some attention has been given to the problem of training.

The Federal Old-Age and Survivors Insurance system appears to be well administered. Activities involved are for the most part of the nondiscretionary type, and operations are such that standardiza-

tion can be fairly easily achieved and mechanical equipment used. The Bureau administering the law has been highly praised for its efficiency. The railroad retirement system also appears to be reasonably well administered. Yet by law railroaders are entitled to some preference in appointments and such preference is likely at some points to run counter to efficiency.

State administration in general appears to be less efficient than the Federal. The first modern labor administrative machinery in this country was established by Wisconsin in 1911. Progress along the same line was made in other states, but slowly. It was not until the coming of unemployment compensation and federally subsidized public assistance programs that marked progress was made in state administrative machinery and in the level of efficiency achieved. Even so, substantial improvements still appear to be possible.

The original Social Security Act did not require that states establish and maintain personnel merit systems as a condition for the approval of their programs. This requirement was insisted upon by the Social Security Board from the beginning and was made a legal requirement by the 1939 amendments. As a result, all states now have personnel merit rating in one form or another for unemployment compensation and for the federally subsidized public assistance programs.

The basic principles of those systems include competitive examinations open to all qualified persons, selections of the best candidates by objective examinations, equal pay for equal grades of work, security of tenure after a trial period, promotion and advancement on the basis of merit, and the right to appeal. Personnel reviews are carried on by the Federal government, but the Federal government has no control over the selection, tenure, and compensation of state employees. Furthermore, the Federal government has been of assistance in helping some states to organize their work and their personnel.

An anomalous situation exists with regard to the administration of unemployment compensation. The Federal government pays all of the necessary and proper costs of administering state unemployment compensation laws, although it has no control over the actual administration of those acts. Federal officers may recommend improved methods, but the states need not adopt those recommendations. Many state officials believe that the Department of Labor is not

supplying them with adequate funds and that Federal budgetary requirements are too inflexible to enable them to plan their operations properly. The Administration in turn believes that the present method of financing is not conducive to economy of operations.

Some recommend as a solution that employers be permitted to offset the entire Federal tax and that the states depend upon their own legislatures for administrative appropriations. Others believe that the Federal government should allocate to each state the amount it collects in taxes from employment in that state. There is no doubt that some states would fare better under either one of these arrangements. But it is certain that many others would not. In the fiscal year ending in 1947, for example, there were 13 jurisdictions in which administrative expenses, all paid by the Federal government, were higher than the amount that would have been yielded had those states received all that was paid to the Federal government by their covered employers. There is not too much assurance that all state legislatures would appropriate adequate funds for administration. They have never done so for other purposes. States may now appropriate money to supplement the Federal grants, yet few of them do so.

The formula adopted in 1954 which returns to the states the excess of Federal collections over employment security administrative expenditures that is not needed for the \$200 million loan fund and permits use of the money for administration should be a workable compromise.

There is no doubt that the previous method of financing unemployment compensation administration was not altogether satisfactory.²⁰ But the situation was certainly not serious. Administration had generally been good. That explains why, despite some rumblings of discontent, there was no great hurry to bring about a change.

MAJOR PROGRAMS

One of the issues confronting the American people today is what should be done about social insurance and public assistance programs. There are many specific proposals, each with its band of loyal supporters. These may be classified into two broad major types.

²⁰ Social Security Administration, *Annual Report, 1947*, pp. 90-91. The problem is discussed by Gladys R. Friedman and Roy O. Kinsinger, in "Federal Responsibility for Payment of State Unemployment Insurance Administrative Expenses," *Social Security Bulletin*, June 1948, pp. 24-29.

One course of action would consist of continuing along the present lines of development, stressing social insurance programs, with the intention of eventually reducing public assistance to an absolute minimum. The other would be to abolish social insurance as we know it and to institute in its stead a universal basic relief program with a means test.

Insurance and Relief. The first course of action was proposed by the Social Security Administration, which consistently recommended steps in this general direction, and by the Senate Finance Committee's Advisory Council on Social Security. It is also the course which has the greater following. The Administration has made two broad and basic recommendations which sum up the action that should be taken. These will be presented and briefly amplified.

First the Administration recommended "a comprehensive basic national system of contributory social insurance, covering all major risks to economic independence and all workers and their dependents threatened by such risks." This would mean closing the coverage and benefit gaps in existing schemes, such as including the self-employed, agricultural and household workers, military personnel, public employees, and employees of nonprofit organizations in the Old-Age and Survivors Insurance system, and where indicated also in the unemployment compensation systems, and increasing the size of benefits all down the line. It also means broadening the scope of coverage in workmen's compensation laws by making them applicable to all occupational injuries and diseases, and increasing the size of benefits paid. Beyond that, it also means the establishment of a comprehensive system of medical and hospital care, such as was contemplated by the Wagner-Murray-Dingell bill, and the establishment of both temporary and permanent nonoccupational disability systems for paying cash disability benefits.

The Administration's second recommendation was "a complete program of public assistance, on a Federal-State basis, under which payments and services financed from Federal and State funds would be available to any needy person in the United States, irrespective of the reason for need or the place of residence." Persons who for one reason or another are not protected by social insurance, or whose social insurance benefits are not adequate to meet their minimum essential needs, would receive relief. Here again the object is in part to close the coverage and benefit gaps in existing "categorical" relief plans, such as old-age assistance, aid to dependent children, and aid

to the blind. It means also that perhaps other categories might be established, and that "general" assistance, which is not now federally subsidized, would receive financial support from the Federal government. The use of a means test would be necessary to determine who is in need and the extent of that need.

Relief Without Insurance. A fundamentally different type of proposal which is receiving a measure of support has been made by Lewis Meriam, one of the leading authorities in the fields of social insurance and public assistance.²¹

One part of the proposal is that our social insurance benefits be discarded altogether, lock, stock, and barrel, although Mr. Meriam would continue some form of social security tax. This would mean abolishing the Federal Old-Age and Survivors Insurance and the Railroad Retirement systems, and probably all other Federal and all state and local retirement systems for public employees as well.²² It would mean abolishing all governmental unemployment compensation programs, and all cash disability systems. Compulsory health insurance would naturally enough not be established. It would mean also the abolition of workmen's compensation plans, which provide cash benefits and medical care in cases of occupational disability.²³ However, it is conceded that under certain circumstances, too complex to be determined without considerable study, something might be paid on account of occupational injuries.²⁴

According to this view, little if anything can be said in favor of our system of social insurance. A formal social security, including insurance and assistance, it is argued, is a minor factor in any program of achieving economic stability in the world today. Wars, for example, disrupt economic stability, as do many other factors. Social security in its broadest and most basic sense is dependent upon the productive efficiency of the economy, on international peace and trade, and on reasonably full employment. Social insurance con-

²¹ See his *Relief and Social Security*, The Brookings Institution, 1946, especially Part III. Mr. Meriam gives a brief statement of some of his views in "Papers and Proceedings of the 59th Annual Meeting of the American Economic Association," *American Economic Review*, vol. xxxvii, No. 2, May 1947, pp. 335-344. Additional pertinent material by others, including dissenting views by Edwin E. Witte and Gerhard Colm, will be found in the same reference.

²² State and local systems could be thought of as jointly contributory plans similar to some found in private industry and therefore not a part of our social insurance system.

²³ See Lewis Meriam, *Relief and Social Security*, p. 562.

²⁴ *Ibid.*, pp. 627-629.

tributes very little, if anything at all, to the achievement of any of these major basic results.

Real social security depends on the possession of adequate quantities of such things as food, clothing, shelter, medical care, and recreation, rather than on the receipt of fixed money payments. Social insurance provides only money payments, fixed on the basis of certain objective factors, such as past earnings and length of service, and those money payments usually remain unchanged, at least for substantial periods of time. Most of those who receive social insurance payments depend mainly if not altogether upon them for the necessities of life. Assuming peace and productive efficiency, the value of those fixed payments can be reduced or destroyed by increases in the level of prices and wages. A democratic, elective government, even though it be charged with the responsibility for maintaining economic stability, will hesitate to take drastic steps to check upward movements of prices. Governments which make the insurance payments are frequently confronted with other claims which they consider much more important. Political expediency rather than concern for beneficiaries is likely to determine courses of action, to the detriment of social insurance beneficiaries.

Many unfortunate people for one reason or another do not have income enough for their maintenance. They are to be found among children unable to take advantage of educational opportunities, women with children to care for, unemployable men and women, unemployed and partially employed persons, and the aged. For those who are thus in need, public money would be made available, sufficient in amount to supply the necessities of life at the prevailing price level. This is the second part of the proposed program.

A "reasonable and well-defined" minimum standard of health and decency would be established below which no one, except persons needing care, treatment, or restraint in specialized public institutions, would be permitted to fall, whatever might be the reason for the need. The standard would vary as between different communities, for in each case it would reflect the customs, desires, and conditions of the local community, and not an average standard for the nation as a whole or for a region.

A means test would be applied to determine whether or not an applicant is entitled to relief and to how much relief he is entitled. It is believed that much of existing hatred of the means test results from the crude forms used in the past and from the manner in which

they were applied. Considerations of sobriety and morality could be abolished altogether or held to a minimum. Unlimited discretion on the part of government officials is not inherent in a means test, and furthermore, applicants for relief who feel themselves aggrieved should be allowed appeal to a higher authority. Incidentally, the greater the discretion vested in local administrators, the greater, usually, are the benefits given to applicants for relief. It should not be too difficult to determine fairly objectively the existence and the extent of need.

In cases where government services would restore or develop economic efficiency, such as vocational training or medical treatment, they would be offered to applicants for relief who need them, and their acceptance should be made a condition for receiving the relief payments. Credit devices would be developed to assist persons with property whose solvency is endangered by the type of personal disaster generally covered by social insurance systems.

The funds necessary to finance such a general relief program could be raised by a special earmarked universal flat income tax with no exemptions and applied to the entire income, or by a Federal retail-sales tax²⁵

There is, according to this view, a question as to how far the government should go in the redistribution of income, and the proposed relief program would take from the taxpayers the minimum amounts required to relieve need. It is believed that the cost would be about half that of a comprehensive system of social insurance.

The American system of free enterprise, and our Federal form of government with its decentralized power and great opportunities for initiative, have developed a high level of productivity. Mr. Meriam says:

. . . I would preserve for the American citizen the maximum possible opportunity to venture with his time, his talents, and his earnings. I would not compel him to put so much of his earnings into social insurance systems either through direct contributions or indirect taxes that he has little in the way of stakes for risk-taking. If the United States is to preserve its leadership, it must give full opportunity to the uncommon man who above his fellows possesses talents or inspiration. These are the people who advance civilization. Money spent in giving opportunity for talent to demonstrate itself and to develop means more for the social security of the nation

²⁵ Harley L. Lutz, *American Economic Review*, vol. xxxvii, No. 2, May 1947, p. 355.

than money spent to protect an individual from the humiliation of a means test.²⁶

One Versus the Other. The principal difference between these two major courses of action is that one of them involves the application of insurance principles in so far as it is possible to apply them. Granted that, among other things, social insurance is not the same as commercial insurance, that it cannot be applied to all persons and hazards, that there is in it some element of pure relief given without a means test and some of it to people who are not in need, that imperfections, inconsistencies, and injustices abound in its application, are indeed inherent in its application, that beneficiaries receiving fixed payments are at the mercy of rising prices and heartless politicians, that the "costs" are high, and admitting even, for the sake of the argument only, that the effect on the efficiency and stability of the economy may be somewhat adverse and cannot at best be beneficial, yet many believe that even so some insurance is better than none, and that the more of it there is the better.

We must be on guard against a common fallacy found in much of the reasoning about social insurance, and about economic systems as well. It is common to analyze a system in operation, to point out inherent contradictions in different parts of that system and even within each part of it, to indicate the many major and minor defects to be found in its structure and functioning, and then to compare these actual conditions with the results that would theoretically be achieved under some other system, which other system is assumed, usually tacitly, to operate perfectly in all respects. To be consistent, one should compare the theory of one system with the theory of the other, and the practice of one with the practice of the other. Where the practice of one system is to be found only or mainly in some other country, where people and conditions are different, a significant comparison of practice is difficult, usually impossible. Yet such comparisons are frequently the basis on which major changes are proposed.

It should be realized that no comprehensive system of any kind, especially if it is a large one, is likely to be without some structural imperfections and many operating inconsistencies and defects. That would be true of any governmental system, whether totalitarian or democratic, and it would be especially so of a democratic system.

²⁶ *American Economic Review*, vol. xxxvii, No. 2, May 1947, p. 342.

It is true also of private insurance systems, whether commercial or nonprofit. Some attention has been given in previous chapters to the inadequacies and imperfections of voluntary nonprofit insurance systems. A study of commercial insurance of any kind would reveal many glaring inadequacies, inconsistencies, and abuses. It will be recalled that in the introductory chapter of this book it was pointed out that one part of the history of insurance was said to be "a story of cheating, arson, murder, and crime of every imaginable sort."

In any event, consistency in structure and perfection in operation are not the only criteria by which to judge the merits of a social security or a social insurance system. In a democracy, the problem is basically to construct a system that reflects generally the ideals of the majority, with such imperfections as political expediency makes necessary or desirable, and to operate that system with as few inconsistencies and defects as possible, whether it be insurance or relief or a combination of the two. The political expediency that oils the wheels of a democracy results in many and varied inconsistencies, imperfections, and even excrescences, but to most of us it is preferable to the theoretical consistency of a totalitarian order, assuming it can be achieved there, whatever brand of totalitarianism it may be.

What basic course of action any one person believes should be followed, or what constitutes a "satisfactory" program, depends largely upon that person's concept of the kind of social order he cares to live in, and to see others live in. That in turn depends on many different things, including among others economic and social status, economic and political philosophy, and upon one's judgment of what effects will be produced by certain procedures.

Either of the two major courses of action described above is compatible with freedom, democracy, Christianity, capitalism, and with other basic concepts held by large numbers of honest and intelligent Americans. But there appears to be nothing inherent in either course of action that would compel all reasonable men and women to accept either as the only just and proper one.

There is but little doubt as to what kind of system the American people want. The discussion of the factors that have brought about what we now have would seem to indicate clearly enough the direction in which we wish to travel. That consists of a combination of insurance and relief. Each legislative session, Federal and State, sees literally hundreds of attempts to broaden the coverage and to in-

crease the benefits of social insurance programs, and no serious attempts to substitute relief for insurance.

A Proposal. The author of this book accepts a combination of social insurance and relief as the best possible, or the most desirable, system for the United States at this time. But the present combination of the two and some of the present trends do not appear to be the most desirable.

It seems altogether proper to cover all the "major risks to economic independence and all workers and their dependents threatened by such risks," as the Social Security Administration proposes. There most certainly should be systems of old-age, disability, and unemployment insurance. There remains, however, the question of how much of each individual loss resulting from unemployment and disability should be compensated through compulsory social insurance schemes.

Unemployment compensation laws have a waiting period of one week before compensation payments begin. When the laws were first enacted, most of them had a two-weeks waiting period. Cash disability benefit plans are following the same practice of a short waiting period. It appears that if and when compulsory medical care plans are established, the aim will be to cover all calls by doctors, and probably all prescription costs as well.

The practice of covering all or part of minimum losses is apparently based largely on the assumption that most of those covered depend entirely, or almost entirely, upon their weekly pay checks for their current essentials. This does not appear to be a realistic assumption. Wage earners are not, to be sure, well-heeled with financial reserves and solidly buttressed with excellent credit ratings. But most of them are well enough off economically to weather a short spell of adversity, a short period of time during which they are not on a pay roll. The great bulk of American workers do not live on a hand-to-mouth, day-to-day basis.

A very substantial amount of social insurance money is being paid to workers suffering seasonal and short-time unemployment, and cash disability benefits are being paid out for relatively insignificant illnesses. Any medical care plan that supplies care for all illnesses and money for minor prescriptions will likewise undertake to carry a heavy total load of relatively insignificant individual burdens. Money payments of this kind can contribute practically nothing to the basic security of most American workers, for the money which

they receive in small quantities is generally not needed for immediate essentials and consequently much of it is spent for goods and services that they could for a time get along without. Such payments may help somewhat to maintain a given level of consumer expenditures and a given level of living, but they contribute very little to the overall stability of the economy and practically nothing to an individual sense of security against possible serious losses.

It might well be better to make unemployment and cash disability compensation and medical care insurance applicable to what for want of a better term may be called catastrophic cases.²⁷ For cash benefits under these systems there could be a longer waiting period, say six or eight weeks. For medical care, the first few visits by a physician and the first few days of hospitalization, say the first four or five, could be excepted from coverage, although for occupational injuries medical care might well be provided immediately and cash benefits paid after a short waiting period. Major surgical and specialist services are essentially catastrophic in character and could be covered without a waiting period. A "retroactive" feature could easily be included under which in cases of unemployment and disability reaching catastrophic proportions the long waiting period, or portions of it, would be compensated.

With such a system it should be possible to offer very substantial benefits for fairly long periods of time. It might be possible, for example, to offer a worker unemployment and cash disability benefits and medical care in substantial amounts for an entire year after the waiting period, and at a relatively moderate cost. That should give most covered workers a greater sense of security than they can generally get from existing benefit structures, a sense of security against what is really dreaded, namely prolonged unemployment or illness. The cost of administration should be substantially reduced, and many of the petty abuses now encountered would no longer exist.

There are some who do depend upon their weekly earnings for their current subsistence, who have little or no margin in their level of living, no reserve, and no credit to tide them over small reverses. For them, catastrophe insurance will not suffice, and something else

²⁷ This type of plan was advocated for unemployment insurance by Alvin H. Hansen and Merrill G. Murray, in *A New Plan for Unemployment Reserves*, University of Minnesota Press, 1933, and by Alvin H. Hansen, Merrill G. Murray, Russell A. Stevenson, and Bryce M. Stewart, in *A Program for Unemployment Insurance and Relief in the United States*, University of Minnesota Press, 1934.

must be provided. That something else can only be relief, whatever it may be called. With present benefit rates and durations, those people would in cases of prolonged unemployment or illness go on relief anyway, since benefit durations are relatively short and benefit rates are not substantial. The proposal suggested here is that if necessary they should go on relief before benefit payments are made rather than after benefits have ceased, or while they are being paid. It is recognized that something can be said in favor of the current fiction of calling relief payments social insurance. But it is uneconomical and socially undesirable to deprive the great majority of protection against heavy losses in order to keep a few from accepting relief which is clearly designated as such.

Age and disability retirement pose a different problem in some respects. It is known that the duration of retirement will usually be long, normally until death, except of course for those cases in which retired workers temporarily return to employment, and workers considered permanently disabled who recover sufficiently to enable them to reënter the labor market. There is no good reason why retirement payments should not begin immediately. It would, however, be desirable to offer higher retirement benefits to those who postpone their retirement. Administration of retirement systems is not too difficult, since there is relatively little discretion involved and opportunities for abuse are not great.

Obstacles to Improvement. A democratic system of social insurance or relief, or a combination of the two, particularly a relatively young one, is likely to be pretty much of a hodgepodge. Ours is certainly that. The tinkering that is being done with what we now have is as often as not the result of attempts by or on behalf of classes or groups to acquire or maintain some special privilege as it is to improve the system as a whole. The prospects of a better general system are not especially bright, whatever may be meant by a "better system."²⁸

There are technical obstacles to a general improvement, such as persistent differences in wage levels and living standards, which reflect geographical economic specialization and regional differences in cultures. Problems are involved, whether these differences are taken into account or ignored.

Secondly, organized labor, more powerful than it has ever been

²⁸ Eveline Burns, in Seymour Harris (ed.), *Economic Reconstruction*, McGraw-Hill Book Company, Inc., 1945, pp. 393-396.

before, and probably becoming even more powerful, generally insists on favorable differentials. This is especially true of the big railroad brotherhoods, who have built for the railroad industry a separate system of social insurance which is considered by many to give them special privileges.

There is thirdly a fairly widespread distrust of the possible future actions of the Congress, especially a fear of what pressure groups might do. A general attempt to overhaul the national system would be a signal for all pressure groups to redouble their activities, to secure special privilege or to protect the special privilege they now have, a signal which they most certainly would not fail to heed. Congressmen, being what they are, and to state the point mildly, would find it very difficult to achieve rational reform. It is only fair to add, however, that the attitudes of Congressmen would merely reflect the attitudes of the masses of our people, and of the many special groups into which our people are organized.

Fourthly, these attitudes of Congressmen and voters reflect in part a lack of understanding of economic principles. They may perhaps be forgiven for not having that understanding. Economists are not themselves agreed, either on what are sound economic principles or on the economic effects that would follow from specified courses of action. It is not therefore unreasonable for each group to press its own interests. Furthermore, it would seem unrealistic to suppose that powerful groups would not press their special advantages if they knew that their gains would be at the expense of others. That seems to be the purpose for which most groups are organized.

There is finally a marked unwillingness to make that redistribution of functions as between the Federal and State governments which would seem to be necessary to achieve a marked improvement in our system of social insurance. Here again it is possible to exaggerate. For in the first place, there is considerable difference of opinion as to what constitutes a better system, and secondly there is an intense difference of opinion as to what the role of the Federal government should be. Local control is of itself considered by many to be one of the most important elements in a satisfactory system, to be, so to speak, something of an end in itself. Perhaps it would be better to say that many people believe more local control is of greater importance to them than a more rational or more effective system of social insurance. The point, which is really a significant one, is that wholly different elements must be weighed in deciding on what

course of action to take. The "best," or a "better," system is one that fits best, or better, into the general framework of our democratic society. But the framework is being modified and some parts of it are at the moment very much blurred.

Of one thing we can be sure. Our system of social insurance and relief will constantly be subject to pressures from many sources and will constantly change as a result of those pressures. The general trend is mainly in the direction of combining social insurance and relief and improving the blanket protection now available. The drive to cover more and more of minimum losses appears to be irresistible. It may well be that in the course of time we shall decide to follow the pattern established in England or in New Zealand.²⁹ But it would appear that nothing short of a major economic or political upheaval will deter us from our chosen course during this generation.

²⁹ Eveline M. Burns, "Social Insurance in Evolution," *American Economic Review*, Vol. XXXIV, No. 1, Part 2, March 1944, pp. 199-211.

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